



COMPARATIVE ANALYSIS:

Policies Affecting Family Planning Access for Young Women
in Guatemala, Malawi, and Nepal

MARCH 2017

This publication was prepared by James E. Rosen (Avenir Health), Sara Pappa (Palladium), Andrea Vazzano (Palladium), and Elizabeth Neason (Population Reference Bureau) of the Health Policy Plus project.

Suggested citation: Rosen, J.E., S. Pappa, A. Vazzano, and E. Neason. 2017. *Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal*. Washington, DC: Palladium, Health Policy Plus.

Cover photo credits: amslerPIX (Guatemala), Department for International Development (Malawi), and Alma Ayon (Nepal)

ISBN: 978-1-59560-151-3

Health Policy Plus (HP+) is a five-year cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-15-00051, beginning August 28, 2015. HP+ is implemented by Palladium, in collaboration with Avenir Health, Futures Group Global Outreach, Plan International USA, Population Reference Bureau, RTI International, the White Ribbon Alliance for Safe Motherhood (WRA), and ThinkWell.

The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.

TABLE OF CONTENTS

Acknowledgements	vi
Abbreviations	vii
Executive Summary	viii
Introduction	1
Why Focus on the Family Planning Needs of Young Women?	2
A Framework for Examining the Policy Environment that Shapes Access to Family Planning Services for Women	5
Categorizing Policies.....	5
Defining What Constitutes a Supportive Policy Environment for Reaching Young Women with Family Planning Information and Services.....	6
Rating the Policy Environment	6
Country Case Study: Guatemala	8
The Context for Young Women’s Lives in Guatemala	8
Accessing Family Planning Services: The Current Policy Environment for Women Ages 15–19 in Guatemala.....	14
Summary for Guatemala.....	22
Country Case Study: Malawi	23
The Context for Young Women’s Lives in Malawi	23
Accessing Family Planning Services: The Current Policy Environment for Young Women Ages 15–19 in Malawi	30
Summary for Malawi	40
Country Case Study: Nepal	41
The Context for Young Women’s Lives in Nepal	41
Accessing Family Planning Services: The Current Policy Environment for Young Women Ages 15–19 in Nepal	48
Summary for Nepal.....	56
Conclusions	57
References	58

TABLES

Table 1. Assessment of Policy Environment in Guatemala, by Main Element and sub-Element .	19
Table 2. Assessment of Policy Environment in Malawi, by Main Element and sub-Element	37
Table 3. Assessment of Policy Environment in Nepal, by Main Element and sub-Element.....	53

FIGURES

Figure 1. Sexual and Reproductive Health Experience of Women Age 19 in Developing Countries.....	2
Figure 2. Distribution of Pregnancies, by Intention Status and Outcome, Women Ages 15–19 in Developing Countries	3
Figure 3. Use of Family Planning by Women Ages 15–19 in Developing Countries	3
Figure 4. Distribution of Population in Guatemala, 2015	8
Figure 5. Women’s Age at Sexual Debut in Guatemala	9
Figure 6. Yearly Births in Guatemala, by Age Group, 2015.....	9
Figure 7. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Guatemala	10
Figure 8. Women Completing Primary Education in Guatemala	10
Figure 9. Variation in Median Age at First Marriage over Time, Guatemala.....	11
Figure 10. Married Young Women’s Experience with Physical and Sexual Violence in the Last Year, Guatemala.....	11
Figure 11. Use of Contraception by Women Married or in Union, Guatemala	12
Figure 12. Method Mix for Married Women Ages 15–19 vs. Ages 20–24, Guatemala	12
Figure 13. Unmet Need for Family Planning Among Married Women in Guatemala	13
Figure 14. Demand for Family Planning Satisfied in Guatemala	13
Figure 15. Grade for the Policy Environment in Guatemala, by Main Element.....	18
Figure 16. Distribution of Population in Malawi, 2015	23
Figure 17. Women’s Age at Sexual Debut in Malawi	24
Figure 18. Yearly Births in Malawi, by Age Group, 2015.....	24
Figure 19. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Malawi	25
Figure 20. Women Completing Primary Education in Malawi	25
Figure 21. Early Marriage in Malawi (Women, Ages 15–49).....	26
Figure 22. Variation in Median Age at First Marriage over Time, Malawi	26
Figure 23. Forced Sexual Initiation in Malawi	27
Figure 24. Young Women’s Experience with Physical and Sexual Violence, Malawi	27
Figure 25. Use of Modern Contraception by Married and Unmarried Sexually Active Young Women, Malawi	28
Figure 26. Method Mix for Married and Unmarried Women Ages 15–19, Malawi	28
Figure 27. Unmet Need for Family Planning Among Married Women in Malawi	29
Figure 28. Demand for Family Planning Satisfied in Malawi	29
Figure 29. Grade for Policy Environment in Malawi, by Main Element.....	37

Figure 30. Distribution of Population in Nepal, 2015	41
Figure 31. Women’s Age at Sexual Debut in Nepal (Married Women Ages 20–24)	42
Figure 32. Yearly Births in Nepal, by Age Group, 2015	42
Figure 33. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Nepal	43
Figure 34. Women Completing Primary Education in Nepal.....	43
Figure 35. Early Marriage in Nepal (Women 15–49)	44
Figure 36. Variation in Media Age at First Marriage over Time, Nepal	44
Figure 37. Forced Sexual Initiation in Nepal.....	45
Figure 38. Young Women’s Experience with Physical and Sexual Violence, Nepal.....	45
Figure 39. Use of Modern Contraception by Married Women, Nepal	46
Figure 40. Method Mix for Married Women Ages 15–19, Nepal	46
Figure 41. Unmet Need for Family Planning Among Married Women in Nepal	47
Figure 42. Demand for Family Planning Satisfied in Nepal.....	47
Figure 43. Grade for Policy Environment in Nepal	53

ACKNOWLEDGEMENTS

The authors are grateful to the HP+ staff who supported this analysis. Jay Gribble and Reshma Naik provided overall guidance and reviewed various drafts. Amy Sunseri helped in the development of the policy checklist. Marisela de la Cruz for Guatemala, Sandra Mapemba and Madison Mellish for Malawi, and Sujata Rana for Nepal helped with the search for and analysis of policies.

ABBREVIATIONS

DHS	Demographic and Health Survey
ENSMI	Encuesta Nacional de Salud Materno Infantil (Guatemala)
MDGs	Millennium Development Goals
MGDS	Malawi Growth and Development Strategy
MICS	Multiple Indicator Cluster Survey
MOHP	Ministry of Health and Population (Nepal)
MSPAS	Ministerio de Salud Pública y Asistencia Social (Guatemala)
NSO	National Statistical Office (Malawi)
SRHR	Sexual and Reproductive Health Rights (Malawi)
SRHRS	Sexual and Reproductive Health and Rights Strategy (Malawi)
STI	sexually transmitted infection
UNFPA	United Nations Population Fund
WHO	World Health Organization

EXECUTIVE SUMMARY

This comparative analysis report examines the family planning needs of young women ages 15–19 in Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. The analysis drew on national surveys and other secondary data sources to describe the lives of these women and identify, categorize, and analyze policies affecting their access to family planning. The main findings are as follows:

- Guatemala has a large population of adolescents, with significant proportions of young women already married and having children before their 20th birthday. Educational attainment of young women has been steadily improving and age at first marriage has risen slightly over time. Adolescent women have the lowest rates of contraceptive use, highest unmet need for family planning, and lowest levels of demand satisfied for family planning compared to older women. The policy environment for adolescent access to family planning is very supportive. However, gaps remain in the areas of consent policies, policies that address such contextual factors as access to education, and structures needed for the effective implementation of policy.
- Like Guatemala, Malawi has a very young population, with a large proportion of adolescent women already married and having children. Educational attainment is still quite low, with progress somewhat stagnant. Meanwhile, sexual and physical violence affect many young women. Contraceptive use is still relatively low, with high unmet need. The policy environment in Malawi is highly supportive of adolescent use of family planning, with supportive laws, policies, and guidelines consistently in place.
- Similarly, Nepal has a young population. Although the median age at first marriage has been rising, half of women are married by age 18. Nepali adolescents have the lowest rates of contraceptive use and highest rates of unmet need of any age group. Overall, the policy environment in Nepal is very supportive of adolescent family planning use, but this support is somewhat uneven.

All three countries have largely recognized the problems facing adolescent women and are trying to meet their family planning needs. These countries have many of the right policies already in place. Where there are gaps, advocates should work to add to or refine existing policies. What matters most, however, is how well countries implement these policies. Although this analysis did not look in depth at implementation, there are clear signs that implementation falls short. Further analysis is needed on how well countries are implementing key policies and what advocates can do to facilitate implementation.

INTRODUCTION

Ensuring that young women ages 15–19 have access to quality family planning services is a pressing policy need worldwide. Although all young women can face age-related barriers to access, the policy environment can be very different for young women of different marital statuses. Whereas the family planning needs of young unmarried women typically focus on pregnancy prevention, the needs of young married women are often more complex, reflecting a desire to delay a first pregnancy or safely space a subsequent birth. Marital status also has implications for a young **woman's ability to stay in school and can affect chances of injury or death from pregnancy.**

This paper examines the family planning needs of young women ages 15–19 in Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. By shedding light on the situation of young women, the authors hope to inform efforts in the three countries to improve the policy environment. Those improvements may include adding new policies, changing existing policies, and encouraging better implementation of those policies already in place.

This analysis drew on national surveys and other secondary data sources. Through a literature review, online search, and consultation with youth experts, policies affecting young **women's** access to family planning were identified, categorized, and analyzed. Three country case studies synthesize the results for Guatemala, Malawi, and Nepal. Each country case study consists of two main sections. The first paints a picture of the lives of young women in their country while the second examines the policy environment that shapes their access to family planning services.

What Is Adolescent Family Planning Policy?

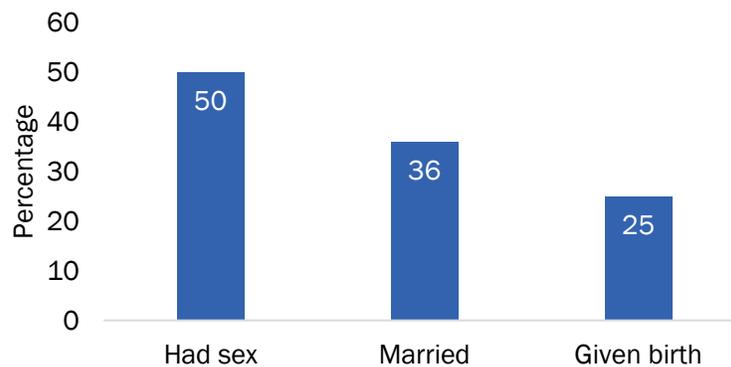
Policy is the result of a process during which governments and other institutions first recognize that a particular need or problem exists and then state their intention to do something about it. These expressions of general concern and the guidelines for action that follow are the essence of policy. When these expressions or statements address the family planning needs or problems of adolescents, they become an adolescent family planning policy. Such a policy can be a stand-alone statement or document, or can be incorporated within broader policies on adolescents or family planning.

WHY FOCUS ON THE FAMILY PLANNING NEEDS OF YOUNG WOMEN?

One out of every six women of reproductive age in less developed countries is age 15–19. This group of 250 million young women is projected to grow to 300 million by 2060 (United Nations, 2015). Meeting their family planning needs is a crucial challenge for all countries. Doing so helps young women achieve their individual sexual and reproductive health and rights, and contributes to the effort of countries to slow rapid population growth, thus further spurring economic and social development.

Although adolescent birth rates have fallen in almost all countries over the past quarter century (Darroch et al., 2016), many women still start having sex, marry, and start having children before they turn 20. By age 19, half of young women in developing countries have had sex, one in three are married, and one in four has given birth (see Figure 1). Roughly half the 21 million pregnancies of adolescent women that occur annually are unintended; a majority end in abortion (see Figure 2). This high proportion of unintended pregnancies is unsurprising, given that only 40 percent of adolescent women in need of family planning use a modern method, 9 percent a traditional method, and 51 percent no method (see Figure 3).¹

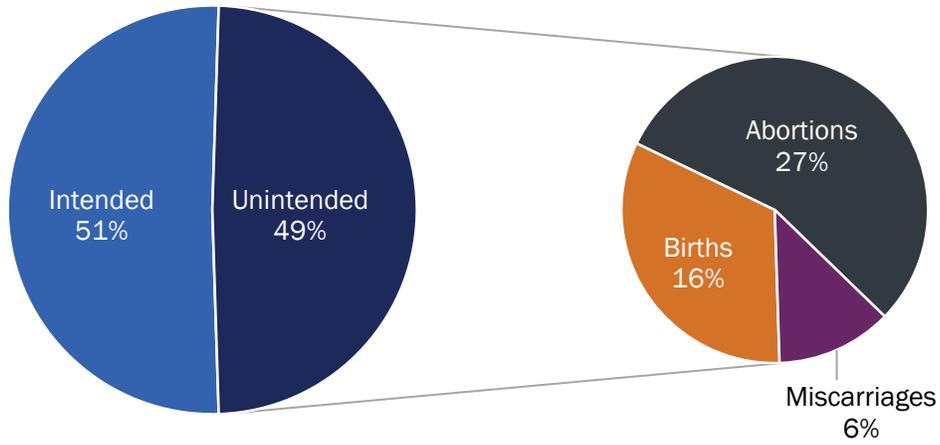
Figure 1. Sexual and Reproductive Health Experience of Women Age 19 in Developing Countries



Source: Darroch et al., 2016

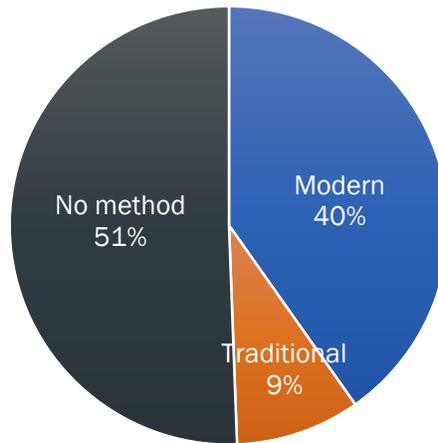
¹ Darroch et al. (2016) estimate that 38 million of the 252 million adolescent women in developing countries need contraception. They define a woman in need of contraception as sexually active and not wanting a child in the next two years.

Figure 2. Distribution of Pregnancies, by Intention Status and Outcome, Women Ages 15–19 in Developing Countries



Source: Darroch et al., 2016

Figure 3. Use of Family Planning by Women Ages 15–19 in Developing Countries



Source: Darroch et al., 2016

What Difference Does Marriage Make for Adolescent Women?

Programs in many countries continue to assume that young women ages 15–19 are unmarried and solely responsible for risky sexual activity and unwanted pregnancy. However, a majority of sexually active adolescent girls in developing countries are married. Though marriage is often seen as the gateway to safe, socially sanctioned sexual relations, it does not reduce—and in fact may increase—girls’ exposure to sexually transmitted infections (STIs), including HIV. The younger a girl’s age at marriage, the more significant the age gap with a spouse tends to be, thus intensifying girls’ disadvantage in bargaining with partners over sex and reproduction. For married adolescents (younger and older), non-health concerns include the curtailment of their education, employment, and other options. The social challenges to adolescent mothers are also substantially neglected. A young adolescent mother is simultaneously dealing with the development of a pregnancy and a new relationship, and is often in a low-power position in her new family. She may even have difficulty in accessing basic antenatal care. Married adolescents could benefit substantially from a more integrated approach to family planning, inclusive of their partners, that would build a foundation for future reproductive health-seeking behavior (WHO and UNFPA, 2006).

A number of countries are clearly falling short in meeting the family planning needs of adolescents, both married and unmarried. This failure can have grave consequences for individual young women, their children, families, and societies. Sex, marriage, and childbearing too early can cut short educational and social opportunities for young women, and have a long-term negative impact on their job and income prospects. Not meeting their family planning needs can also harm their health and that of their children and families. By contributing to higher rates of population growth, early childbearing can also have a negative impact at the societal level. Thus, meeting the family planning needs of this age group is essential.

In addressing the family planning and broader sexual and reproductive health needs of adolescents, an international consensus has emerged about what societies need to put in place to ensure that all young people achieve their family planning goals. These building blocks include quality education; decent work; positive participation in their communities; human rights protections; and access to sexual and reproductive health information and services. Yet, for the vast majority of adolescent women in developing countries, these building blocks are out of reach.

Standing in the way of adolescent women are a range of social, economic, and legal and regulatory obstacles. These include gender inequalities, poor communication between parents and their adolescent children, negative attitudes of health workers, lack of educational and economic opportunity, and lack of investment in the human capital of adolescents and young people. Age-of-consent laws are a specific barrier to access in many countries. Moreover, the policy environment in many countries has not caught up to the commitments that almost all countries have made, via international treaties and conventions, to respect the rights and address the sexual and reproductive health needs of adolescents.

A FRAMEWORK FOR EXAMINING THE POLICY ENVIRONMENT THAT SHAPES ACCESS TO FAMILY PLANNING SERVICES FOR WOMEN

The policy environment is one important factor that can determine whether a person age 15–19 can access needed family planning services. Policies can be important, both for what they say and what they do not say. Moreover, policies are just a first step—whether a country implements a policy depends on many factors.

Categorizing Policies

In thinking about the policy environment, it is useful to group the various types of policies that can influence access into four main categories.

1. Laws, treaties, and conventions

Laws. Legislation can be an important policy instrument by introducing legally binding commitments to promoting young people’s reproductive health. Examples include laws that guarantee access by minors to certain reproductive health services, set a minimum age for marriage, and ban female genital mutilation.

Constitutional provisions, judicial decisions, and executive orders. Like laws, these are legally binding commitments.

Treaties and conventions. By signing international treaties and conventions, countries formally express their commitment to addressing issues relevant to adolescents and family planning.

2. Policies and strategies

Population policies. These encompass broad national or subnational policies that may include language on youth reproductive health.

Youth reproductive health policies or strategies. Such policies focus exclusively on youth reproductive health.

Youth policies. These broad policies cover all aspects of the lives of young people, including reproductive health.

3. Political statements

Political statements. Speeches and other statements by political leaders can have an important effect on the policy environment. These do not have the status of laws or written policies but can often influence the policy environment on specific issues.

4. Operational policies, standards, and guidelines

Operational policies, standards, guidelines, and professional standards of practice. Typically (but not exclusively) applied to public sector services, such policies influence the actions and attitudes of health workers and others that serve young people. They include rules,

regulations, guidelines, operating procedures, and administrative norms that governments use to translate national laws and policies into programs and services.

Standards of practice in professional fields. These include policies set by national, regional, or local professional bodies, such as associations of doctors, nurses, pharmacists, and teachers.

Defining What Constitutes a Supportive Policy Environment for Reaching Young Women with Family Planning Information and Services

To gauge how well the policy environment supports family planning use by adolescent women, six key elements were defined. A supportive environment should do the following:

- 1. Create or ensure the establishment of a national policy on family planning for adolescents ages 15–19.** A country must have in place policies that explicitly promote adolescent access to family planning information and services. Countries also need policies that link family planning to other critical sexual and reproductive health needs of adolescents and broader health and development goals. Countries should also sign international agreements supporting adolescent access to family planning.
- 2. Ensure that consent policies and unnecessary age or marital status restrictions are not a barrier to family planning use by adolescent women.** Laws, regulations, policies, and guidelines should be free of language that requires a woman age 15–19 seeking family planning to obtain consent from a parent, spouse, or health worker. They should also not impose unnecessary restrictions based on age or marital status.
- 3. Promote human rights.** The policy environment should prevent rights violations and practices that have a broadly harmful effect on adolescent women and a specific negative impact on their access to family planning. These practices include child marriage, gender-based violence, and female genital cutting.
- 4. Promote a tailored approach to serving adolescents.** The policy environment should recognize that adolescents have specific family planning needs and promote a tailored approach to their care.
- 5. Address contextual factors.** The policy environment should address key contextual factors that influence adolescent access to information and services, including education and gender.
- 6. Support implementation.** Finally, the policy environment should support the implementation of policies that are consistent and include explicit funding levels for adolescent programs, accountability mechanisms, and necessary data collection. Note that this framework does not explicitly measure the degree to which policy is implemented. Other tools, such as the Policy Implementation Assessment Tool, examine implementation in depth (Bhuyan et al., 2010).

Rating the Policy Environment

To grade the policy environment for each country in this analysis, the authors developed a checklist of questions related to each of the six elements described. The authors created the checklist drawing from work done under previous iterations of the Health Policy Plus project, including the youth-policy.com website (<http://www.youth-policy.com/index.htm>), the Family

Planning Effort Index (Ross and Smith, 2010), and the Policy Checklist (Health Policy Project, 2014).

For each question in the checklist, a “yes” answer was given a score of 1. An answer of “partially” was given a score of 0.5. A “no” answer received a score of 0. Unweighted scores were summed for each element and overall, and scaled from 0–100. Grades were assigned based on the following ranges:

- Unsupportive 0–29
- Somewhat unsupportive 30–49
- Somewhat supportive 50–69
- Very supportive 70–89
- Highly supportive 90–100

The checklist and score for each country is included in the following country case studies.

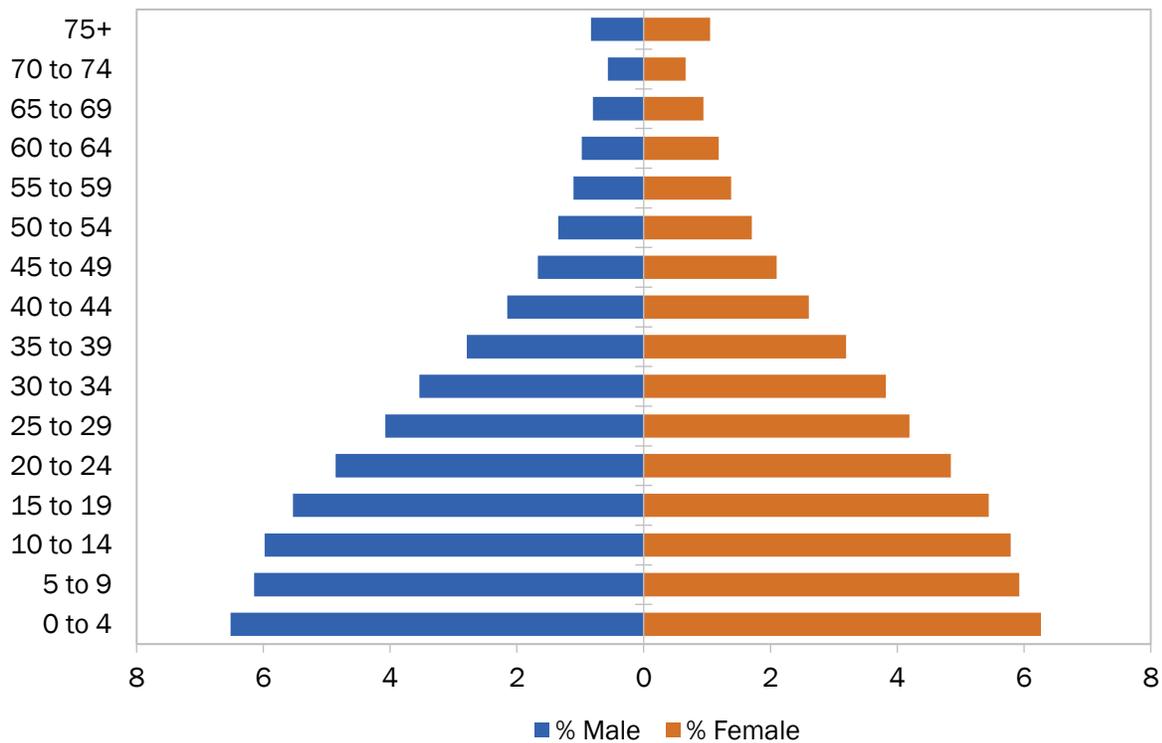
COUNTRY CASE STUDY: GUATEMALA

The Context for Young Women’s Lives in Guatemala

Age structure of the population

About half of the population in Guatemala is under age 20 (see Figure 4). Of Guatemala’s total 2015 population of 16.3 million, 1.8 million were between 15 and 19 years old, equally split between men and women.

Figure 4. Distribution of Population in Guatemala, 2015

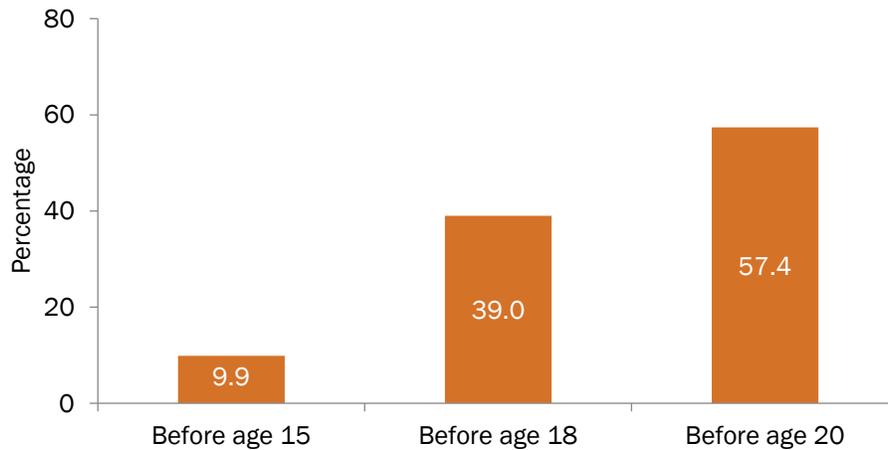


Source: United Nations, 2015

Age of sexual debut

A significant proportion of young women in Guatemala start having sex at a very young age. Of women ages 20–24, 10 percent began having sex by age 15; by age 18, 39 percent had their sexual debut (Figure 5).

Figure 5. Women’s Age at Sexual Debut in Guatemala

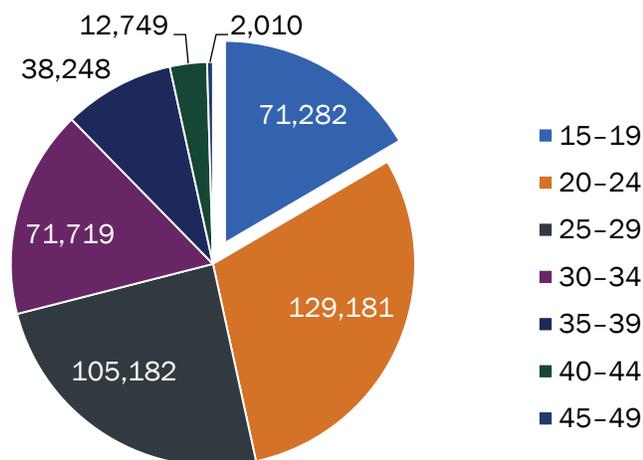


Source: Encuesta Nacional de Salud Materno Infantil (ENSMI) 2008/09 (MSPAS, 2010)

Birth rates

Of the 430,732 babies born each year in Guatemala, about 71,000 are born to adolescent girls, representing approximately 17 percent of all births in the country (Figure 6). Rates of adolescent childbearing in Guatemala are high. The birth rate for women ages 15–19 is 92 per 1,000, meaning that, on average, 9.2 percent of young women ages 15–19 give birth every year (MSPAS et al., 2015).

Figure 6. Yearly Births in Guatemala, by Age Group, 2015

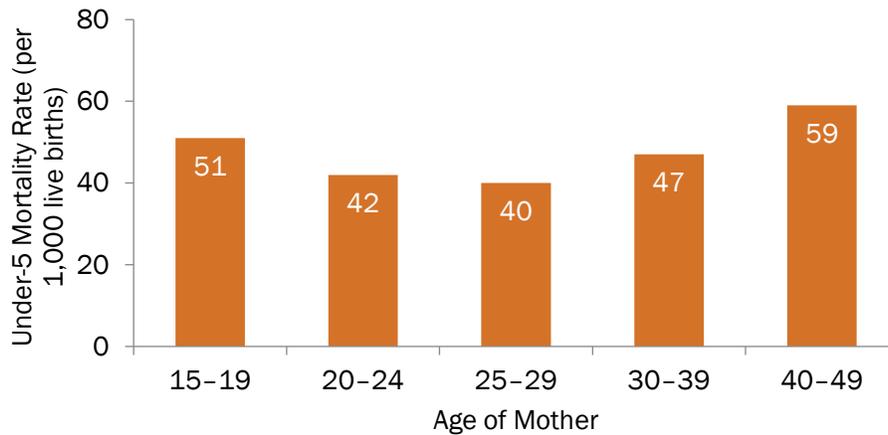


Source: United Nations, 2015

Child death rates

Mothers who give birth before age 20 are more likely than women ages 20–39 to have a child who dies by age 5 (Figure 7).

Figure 7. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Guatemala

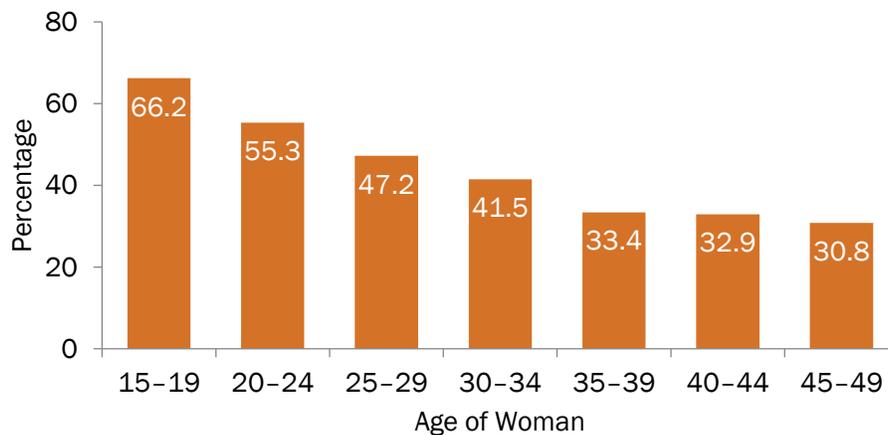


Source: ENSMI 2008/09 (MSPAS, 2010)

Educational attainment

Approximately 66 percent of girls ages 15–19 have completed at least a primary education (Figure 8). Notably, this percentage drops significantly with older age groups, meaning today's young women have a better chance at education than did their mothers and grandmothers.

Figure 8. Women Completing Primary Education in Guatemala

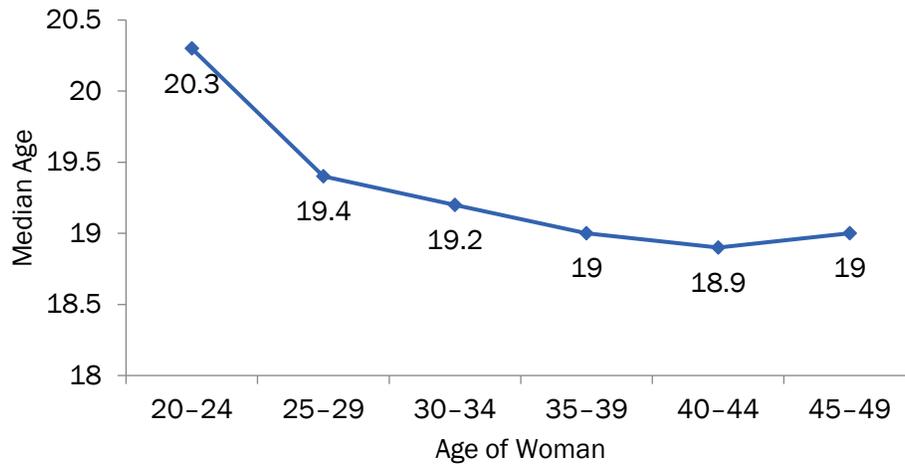


Source: ENSMI 2008/09 (MSPAS, 2010)

Early or coerced marriage

Overall, Guatemalan women are marrying at later ages compared with earlier generations, with the median age at first marriage 20.3 for women ages 20–24 versus 19 for women ages 45–49 (Figure 9).

Figure 9. Variation in Median Age at First Marriage over Time, Guatemala

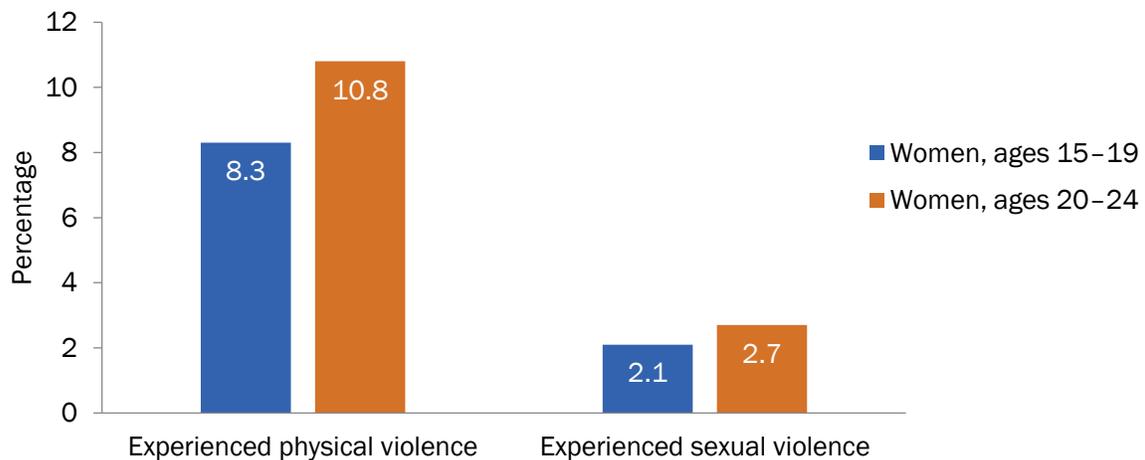


Source: ENSMI 2008/09 (MSPAS, 2010)

Violence against young women

Approximately 8 percent of married women ages 15–19 in Guatemala reported experiencing physical violence and 2 percent sexual violence in the past year (Figure 10).

Figure 10. Married Young Women’s Experience with Physical and Sexual Violence in the Last Year, Guatemala

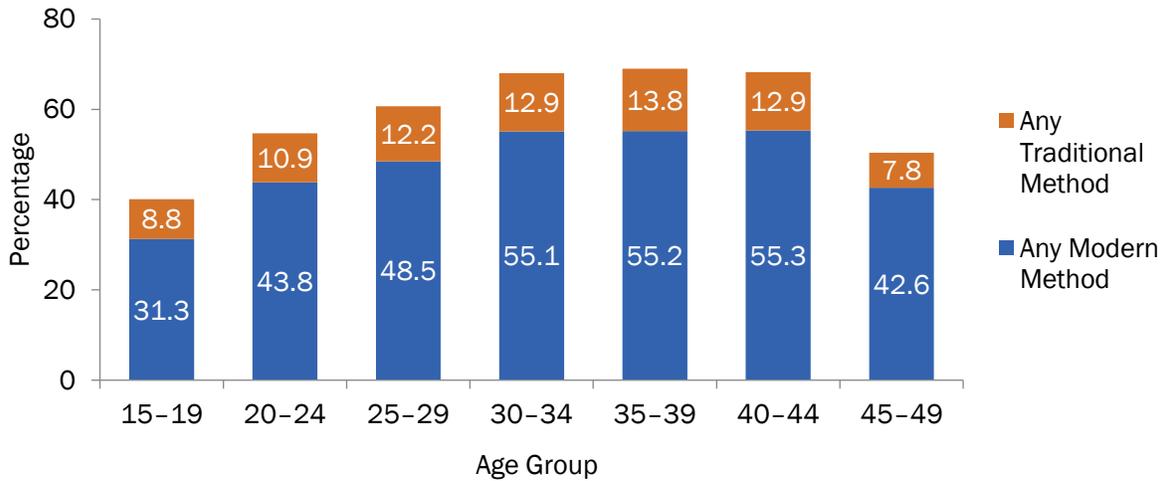


Source: ENSMI 2014–2015 (MSPAS et al., 2015)

Contraceptive use

Approximately 31 percent of married women ages 15–19 are using a modern method of contraception, a percentage significantly lower than for older women (Figure 11).

Figure 11. Use of Contraception by Women Married or in Union, Guatemala

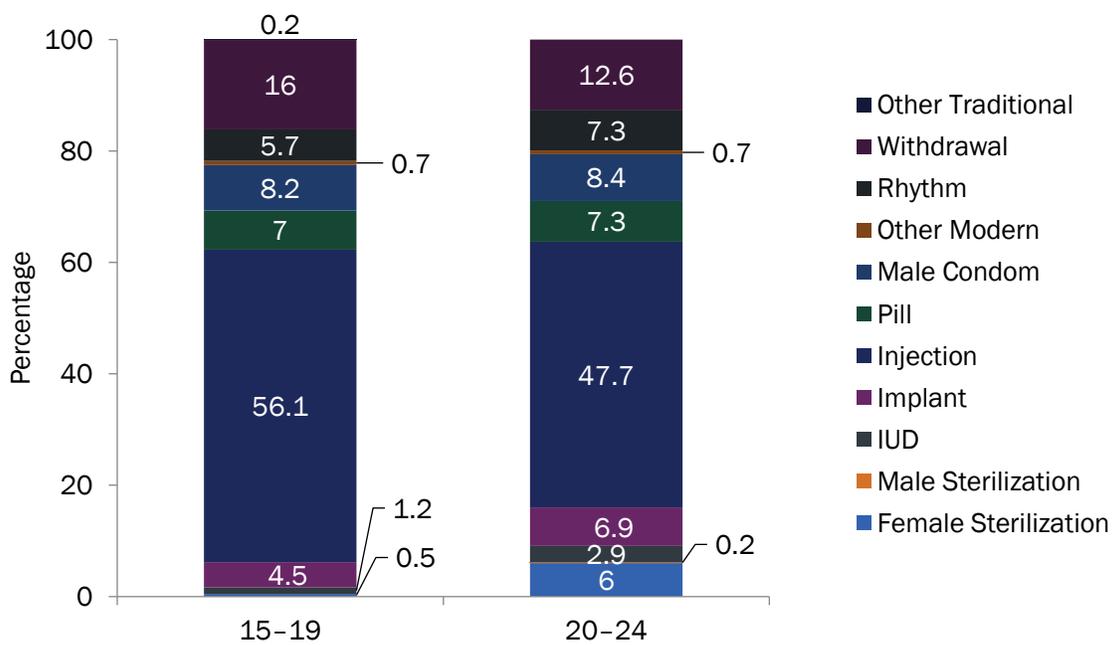


Source: ENSMI 2014–2015 (MSPAS et al., 2015)

Contraceptive method mix

By far, the preferred method of family planning for married women ages 15–19 is the injectable contraceptive, accounting for over half of all method use (Figure 12).

Figure 12. Method Mix for Married Women Ages 15–19 vs. Ages 20–24, Guatemala

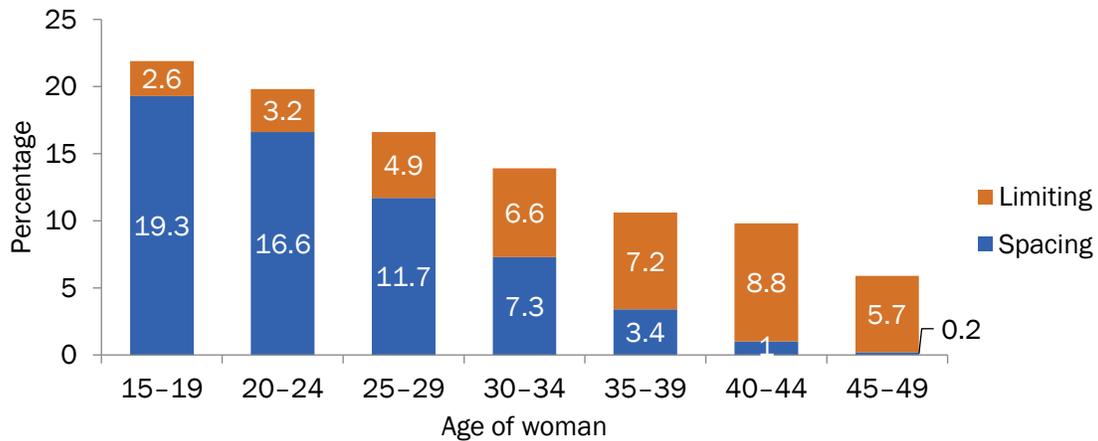


Source: ENSMI 2014–2015 (MSPAS et al., 2015)

Unmet need for family planning

Among married women, 22 percent of those ages 15–19 have an unmet need for family planning, higher than for any other age group (Figure 13).²

Figure 13. Unmet Need for Family Planning Among Married Women in Guatemala

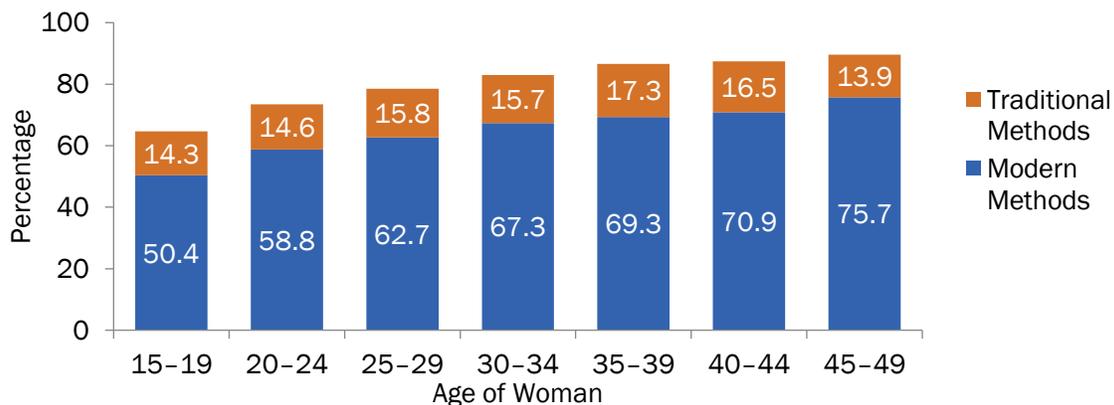


Source: ENSMI 2014–2015 (MSPAS et al., 2015)

Family planning demand satisfied

Young women ages 15–19 have 50 percent of their demand for modern family planning satisfied and 65 percent of demand satisfied for all methods—the lowest levels of any age group (Figure 14).³

Figure 14. Demand for Family Planning Satisfied in Guatemala



Source: ENSMI 2014–2015 (MSPAS et al., 2015)

² Women with unmet need are those who are fecund and sexually active but not using any method of contraception, and report not wanting any more children or wanting to delay the next child. Women with an unmet need for limiting are those who desire no additional children and do not currently use a contraceptive method. Women with an unmet need for spacing are those who desire to postpone their next birth by a specified length of time (for example, for at least two years from the date of a survey) and do not currently use a contraceptive method.

³ The percentage of women with demand satisfied is calculated as the number using family planning divided by the total number of women in need of family planning.

Accessing Family Planning Services: The Current Policy Environment for Women Ages 15–19 in Guatemala

Laws, treaties, and conventions

The 1993 Constitution (La Constitución) grants the right to freely decide the number and spacing of children. The Constitution grants everyone the right to basic education (nine years of schooling). It also explicitly allows couples to freely choose the number and spacing of their children. Although the Constitution does not mention adolescents specifically, these two provisions support access to family planning generally, with the right to education as an important element underlying girls' ability to exercise their rights and understand issues related to family planning and contraception.

The 2003 Child and Adolescent Protection Law (Ley de Protección a la Niñez y Adolescencia, Decreto 27-2003) guarantees the right to healthcare but requires parental consent for medical care. This 2003 national law specifies the rights and obligations of children and youth in Guatemala, defining a child as under age 13 and an adolescent as ages 13–18. It makes no distinction between married and unmarried children. The law guarantees adolescents the right to healthcare but requires parental consent for medical care, except in cases in which the life of the adolescent is in danger. It also contains strong protections against economic exploitation and sexual and physical abuse. Overall, its impact on family planning access and use should be positive, but the parental consent requirement mitigates the positive impact.

The 2005 Family Planning Law (Ley de Acceso Universal y Equitativo de Servicios de Planificación Familiar y su Integración en el Programa Nacional de Salud Reproductiva, 2005) promotes sexuality education and services tailored to adolescents. This 2005 law ensures access to family planning services and mandates sexuality education for adolescents. It names adolescents as one of the groups the law aims to support, calling for equal access to services. It also calls on the government to design an adolescent-specific services strategy integrating health, education, and other sectors. It does not differentiate between married and unmarried adolescents, nor does it define the adolescent age group.

The 2001 Social Development Law (Ley de Desarrollo Social 2001) mandates adolescent-specific reproductive healthcare and sexuality education. Article 16 of this 2001 law designates adolescents as a group requiring special attention. Article 26 mandates the establishment of a public sector reproductive health program whose objective is to reduce maternal and child mortality. It mandates the establishment of an adolescent-specific reproductive health program (specific and differentiated) that includes information and family planning services. Article 29 promotes the establishment of sexuality education for all adolescents. The law, in its totality, should have a positive impact on family planning access for young women ages 15–19. It does not distinguish between unmarried and married adolescents, nor does it define terms such as adolescent and child.

The 2010 Safe Motherhood Law (Ley para la Maternidad Saludable, 2010) supports tailored services for pregnant adolescents and prevention of teen pregnancy. This 2010 law promotes action to reduce maternal and neonatal deaths; such actions encompass strengthening reproductive health programs, including family planning. It identifies adolescents as one of several vulnerable populations requiring attention. In several places, it uses clear and unambiguous language to call for differentiated services for adolescents. Part of the section that addresses immediate actions includes nutritional programs for adolescents and prevention of pregnancy in adolescent girls. The law does not distinguish by marital status, nor does it define

the adolescent age group. This law, if implemented, should have a positive impact on access to family planning services.

The Penal Code (Código Penal) defines any sexual act with a person under 14 as rape. In addition, the law defines sex with a woman ages 13–17 as statutory rape and stipulates a prison sentence for both crimes. Because of these legal definitions, there is some debate in Guatemala about whether it is legal to provide contraceptives to girls under 14. This open legal question has had a somewhat chilling effect on the provision of family planning services to adolescents, especially the youngest ones.

The 2009 Law Against Sexual Violence (Ley Contra la Violencia Sexual 2009) defines any sexual act with a person under age 14 as rape and recognizes that the rights of minors should take precedence. The 2009 law has the objective of preventing, reducing, sanctioning, and eradicating sexual violence, trafficking, and exploitation, with the aim of protecting victims of sexual violence and mitigating its effects. It defines any sex with a person under age 14 as rape. As mentioned above in the discussion of the penal code, this definition has created uncertainty about the legality of providing contraception to girls under 14, producing a chilling effect on services to the youngest adolescents. The law recognizes the important principle of the “best interests” of minors. This concept is enshrined in the Convention on the Rights of the Child, which gives the child the right to have his or her best interests assessed and given primary consideration in all actions or decisions that concern him or her, both in the public and private spheres.

The 2015 Presidential Decree 8-2015 (Decreto Número 8-2015) modifies the Civil Code to set the minimum age of marriage at 18. This 2015 decree set the age of marriage at 18 for men and women, citing child marriage as a human rights violation. The decree allows minors 16 and 17 years old to marry with judicial authorization.

The 2008 Law Against Femicide and other Forms of Violence against Women (Ley Contra el Femicidio y Otras Formas de Violencia Contra la Mujer Decreto Número 22-2008) defines denial of family planning services as a form of sexual violence. This 2008 law aims to protect women from various forms of discrimination and physical, sexual, psychological, and economic violence. Its definition of sexual violence includes the denial of a woman’s right to use family planning services or the means to protect herself against STIs. The law addresses violence against young women specifically but offers only broad protections and sanctions.

Guatemala is a signatory to all relevant international treaties and agreements. These include the Universal Declaration of Human Rights, 1948; Convención Americana Sobre Derechos Humanos, 1969; Convention on the Elimination of Discrimination Against Women, 1979; International Conference on Population and Development, 1994; Convention on the Rights of the Child, 1989; Social Development Summit, 1995; the Beijing Platform of Action, 1995; Convención Interamericana para Prevenir, Sancionar y Erradicar la Violencia Contra la Mujer, 1995; La XVIII Cumbre Iberoamericana de Jefes de Estado: Juventud y Desarrollo, 2008; Social Development Summit, 1995; Convención Belem do Pará, 1994; Convención Iberoamericana de los Derechos de los Jóvenes; Millennium Development Goals, 2000; Declaración Ministerial “Prevenir con Educación,” 2016; and Informe del Relator Especial de las Naciones Unidas Sobre el Derecho a la Educación, 2010. Nonetheless, it should be noted that in signing many of these agreements, Guatemala consistently expressed reservations related to language on reproductive health and rights.

Policies, plans, and strategies

The 2013 National Plan to Prevent Adolescent Pregnancy (Plan Nacional de Prevención de Embarazos en Adolescentes, 2013–17) promotes a holistic approach that includes sexuality education and family planning services. This plan, developed by the National Youth Council, presents a holistic, intersectoral response to the problem of teen pregnancy. It clearly specifies the target group of young women ages 15–19 and defines a series of objectives that include broad investment in youth, access to education, prevention of early marriage, sexuality education, access to contraception, and youth participation in program design and decision making.

The 2014 K’atun National Development Plan (Plan Nacional de Desarrollo K’atun 2032) sets the goal of reducing teen pregnancy and calls for more and better sexuality education and family planning services to meet this goal. The plan, published in 2014, lays out the country’s long-term plan through 2032. It covers a broad range of topics, including education, health, social protection, the environment, and jobs. As part of its priority to transform the healthcare model, the plan promotes the development and provision of integrated and tailored health services for adolescents while encouraging the participation of young people in their design and delivery. The plan sets the goals of eliminating pregnancies in girls younger than 16 and reducing pregnancies in girls ages 17–19. To achieve this goal, it calls for more and better tailored services for adolescents and the implementation of scientifically rigorous sexuality education programs. Although not highlighting adolescents specifically, it calls for family planning and other reproductive health services to be provided regardless of marital status. If implemented, the plan would have a very positive effect on access to family planning services.

The 2004 Public Policy to Protect Childhood and Adolescence (Política Pública de Protección Integral a la Niñez y la Adolescencia, 2004–2014) calls for the expansion of adolescent sexual and reproductive healthcare and prevention of early pregnancy. Currently being updated, this is an overarching public policy and planning document that lays out a coherent vision for the role of the state in protecting the human rights of children and adolescents. The policy defines childhood as encompassing ages 0–12 and adolescence as including ages 13–18. It does not distinguish between married and unmarried adolescents. The document strongly supports the participation of adolescents themselves in policy making. It calls for the creation of specialized services tailored to the health needs of adolescents and their unique characteristics. By calling for the expansion of sexual and reproductive healthcare, and prevention of early pregnancy, the plan should be a positive force in expanding access to family planning services.

The 2012 National Youth Policy (Política Nacional de Juventud 2012–2020) promotes universal access to integrated and tailored sexual and reproductive health services for adolescents and youth. The policy outlines an integrated vision for youth development and recommends actions across a range of sectors, including health. It defines youth as covering ages 13–30, and young adolescents as including ages 13–18. It defines health as one of its strategic areas and describes 15 specific guidelines within health, the first one guaranteeing universal access to integrated and tailored sexual and reproductive health services. Other guidelines cover prevention of teen pregnancy, violence prevention, sexuality education, and broadening the inclusion of young people in the various social health insurance schemes. The policy addresses consent laws indirectly by advocating for applying the existing legal and regulatory framework while considering the rights of adolescents. The policy should have a very positive impact on access to family planning services and information.

The 2003 Adolescent and Youth Health Policy (Política de Salud para la Adolescencia y la Juventud, 2003–2012) promotes an integrated and tailored approach to meeting adolescent health needs, including reproductive health and sexuality education. This Ministry of Health policy, which remains in effect, sets forth an integrated, gender-equitable vision for addressing the health needs of adolescents. It promotes a tailored approach to meeting these needs, including reproductive health and sexuality education. It does not distinguish between married and unmarried, and defines adolescence and youth as spanning ages 10–25.

Operational policies, standards, and guidelines

The 2010 National Family Planning Guidelines (Guías Nacionales de Planificación Familiar) identify adolescents as a group requiring tailored counseling and clinical services. This 2010 update of the family planning program guidelines provides health workers with the latest information on each contraceptive method to better inform their counseling and improve client care. The guidelines highlight the special nature of adolescents as a group and suggest specific ways to tailor counseling to their needs. The guidelines do not distinguish between married and unmarried adolescents, but note that the latter are a special group needing counseling. The guidelines allow voluntary surgical contraception for women age 18 and over. They also recommend against use of progestin-only injectables for women under age 20. The Ministry of Health has drafted adolescent-specific service guidelines but has yet to publish them.

The 2016 Prevention Through Education Agreement (Carta Acuerdo “Prevenir con Educación,” 2016) specifies how the health and education ministries will coordinate action to implement sexuality education in the schools. This 2016 agreement reiterates the commitment made in 2010 between the health and education ministries based on the regional Ministerial Declaration on Prevention Through Education (Declaración Ministerial Prevenir con Educación) that Guatemala signed in 2008 at the International AIDS Conference in Latin America and the Caribbean. In it, countries committed to including sexuality education in their schools. To meet the goals of the declaration, the health and education ministries in Guatemala signed a letter of agreement that specifies how they would coordinate and implement the policy. The declaration does not distinguish between married and unmarried and does not define age groups. By strengthening coordination mechanisms and connecting sectors to improve and expand sexuality education, the agreement should have a very positive impact on access to family planning education and services.

The 2008 Model for Integrated and Differentiated Services for Adolescents (Modelo de Atención Integral y Diferenciada para los y las Adolescentes) calls for the establishment of a normative framework for integrated and tailored services. This 2008 Ministry of Health document provides a general framework for how to provide services to adolescents. It calls for the establishment of a normative framework for integrated and tailored services for adolescents to promote healthy environments and citizen participation.

The “Protect Me From Pregnancy” (Campaña Protégeme del Embarazo) campaign addressed pregnancy in girls younger than 14. This national campaign, which ended in 2016, aimed to raise awareness about the problem of pregnancy in girls younger than age 14. It also aimed to teach girls, their families, schools, health facilities, and communities about what to do to prevent such pregnancies and the rights of the girls. Ultimately, the goal of the campaign was to reduce and eventually eliminate such early pregnancies. The campaign produced a Roadmap to Address Pregnancy in Girls under 14 (Ruta de Abordaje) that included specific steps for girls, families, communities, and legal authorities to follow. As noted in the previous discussion on the provisions of the legal code regarding rape, the effect on family planning access for the youngest adolescent girls may be problematic. Because the law defines any sex act with a girl younger

than 14 as rape, it may dissuade girls in that age group from seeking family planning services, and service providers from providing them with care.

Summary of the policy environment in Guatemala

This assessment applied the framework discussed earlier to gauge the extent to which Guatemala has a policy environment supportive of family planning access to young women ages 15–19. Guatemala received **an overall grade of “very supportive,”** based on a score of 76.6 out of a possible 100 points (Figure 15). In all of the main elements, Guatemala received a grade of at least **“somewhat supportive.”** Guatemala scored highest in the category of human rights and lowest in the category of supporting implementation.

Figure 15. Grade for the Policy Environment in Guatemala, by Main Element

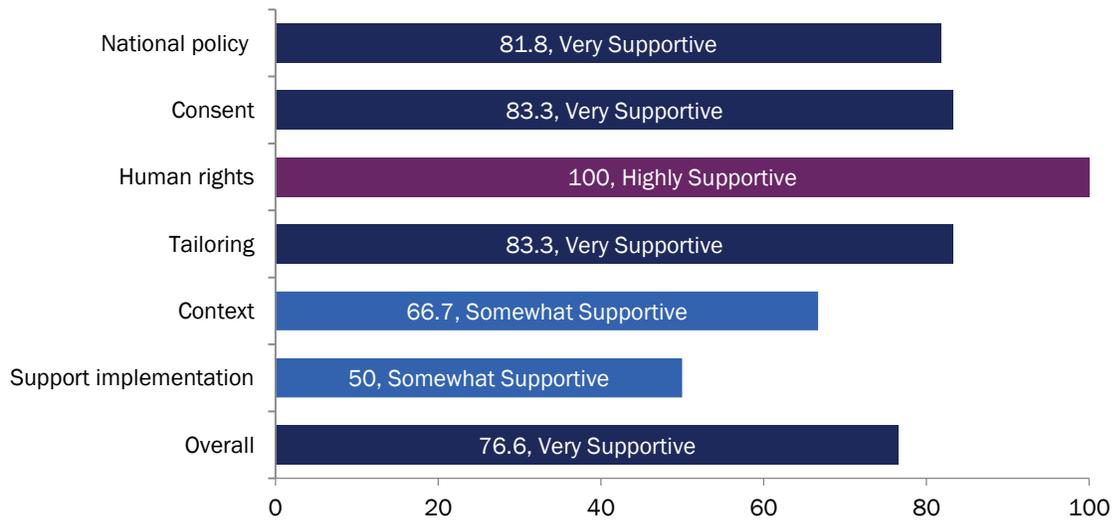


Table 1 shows the scoring breakdown by main element and individual sub-element. In the category of creating and ensuring the establishment of a national policy for adolescents, multiple policies often support adolescent-specific information and services. Only in post-abortion care was the current policy environment judged unsupportive. The consent element of the framework showed some gaps in relation to parental consent and medical eligibility guidelines. In the promotion of human rights, age at marriage policy could be improved. Guatemala scored generally well on contextual factors, but lacks policies on pregnancy and school dropout and readmittance. When it comes to promoting a tailored approach, there also appears to be room for improvement in recognizing differences within the 15–19 age group. In the implementation support category, Guatemala scored low because it lacks a specific budget line for adolescent family planning and is somewhat inconsistent regarding policies on rape, age of consent for sex, and access to family planning services.

Table 1. Assessment of Policy Environment in Guatemala, by Main Element and sub-Element

Element and sub-element	Yes	Partially	No	Comments
<i>Creates or ensures the establishment of a national policy on family planning for adolescents</i>				
Is there a policy that directly addresses provision of family planning to adolescents?	X			Family Planning Law; Social Development Law; Safe Motherhood Law; National Plan to Prevent Adolescent Pregnancy
Are there specific family planning clinical guidelines for serving adolescents?		X		The National Family Planning Guidelines identify adolescents as a group requiring tailored counseling and clinical services, but they have yet to be published
Is there a policy that supports age-appropriate sexual and reproductive health education and information?	X			Family Planning Law; Social Development Law; K'atun National Development Plan; National Plan to Prevent Adolescent Pregnancy; Prevention Through Education Agreement
Do policies promote the establishment of adolescent-friendly health services?	X			Model for Integrated and Differentiated Services for Adolescents
Is there a policy that provides adolescents with access to family planning post sexual assault?	X			The "Protect Me From Pregnancy" campaign addressed pregnancy in girls younger than 14
Is there a policy that ensures there are no missed opportunities for appropriate integration of family planning with post-abortion care?			X	No policy exists
Is there a policy that links provision of family planning to adolescents to broader family planning policies?	X			The Family Planning Law promotes sexuality education and services tailored to adolescents
Is there a policy that links provision of family planning to adolescents to broader health policies?	X			The Adolescent and Youth Health Policy promotes an integrated and tailored approach to meeting adolescent health needs, including reproductive health and sexuality education
Is there a policy that links provision of family planning to adolescents to broader adolescent development policies?	X			The National Youth Policy promotes universal access to integrated and tailored sexual and reproductive health services for adolescents and youth; the Public Policy to Protect Childhood and Adolescence calls for the expansion of adolescent sexual and reproductive healthcare and prevention of early pregnancy
Is there a policy that links provision of family planning to other national development plans and documents?	X			The K'atun National Development Plan sets the goal of reducing teen pregnancy and calls for more and better sexuality education and family planning services to meet this goal

Element and sub-element	Yes	Partially	No	Comments
Is the country signatory to key international agreements that support adolescent access to family planning information and services?		X		Guatemala is signatory to all relevant international agreements but has expressed reservations related to language on reproductive health and rights
<i>Ensures that consent policies and unnecessary age or marital status restrictions are not a barrier to family planning use by adolescent women</i>				
Do all policies eliminate parental consent as a prerequisite for adolescents to use family planning services?		X		The Child and Adolescent Protection Law requires parental consent for medical care; the Law Against Sexual Violence recognizes that the rights of minors should take precedence; the National Youth Policy addresses consent laws indirectly by advocating for applying the existing legal and regulatory framework while taking into account the rights of adolescents
Do all policies eliminate spousal consent as a prerequisite for adolescents to use family planning services?	X			No policies exist requiring spousal consent
Are policies consistent with the latest World Health Organization (WHO) guidelines on medical eligibility criteria for contraceptive use as they relate to adolescents?		X		The National Family Planning Guidelines allow voluntary surgical contraception only for women age 18 and over, and also recommend against the use of progestin-only injectables for women under 20
Do all policies eliminate consent requirements (age, parental, spousal) as a prerequisite for adolescents to use emergency contraception?	X			According to the International Consortium for Emergency Contraception, cecinfo.org
Do all policies eliminate marital status as a prerequisite for adolescents to use family planning services?	X			No policies require adolescents to be married to access services
Do policies set an appropriate age of consent for sex?	X			The National Penal Code sets it at age 14
<i>Promotes human rights</i>				
Do laws and policies prohibit marriage to women younger than 18?	X			Decree 18-2015 sets the legal age of marriage in Guatemala at 18 for both women and men. Individuals ages 16 and 17 can marry with the authorization of a judge.
Do laws and policies exist that discourage the practice of female genital cutting?				Female genital cutting is not practiced in Guatemala
Do policies exist that promote programs to reduce the incidence of female genital cutting?				Female genital cutting is not practiced in Guatemala

Comparative Analysis: Policies Affecting Family Planning Access for Young Women in Guatemala, Malawi, and Nepal

Element and sub-element	Yes	Partially	No	Comments
Do policies exist that promote programs to reduce the incidence of gender-based violence?	X			The Law Against Femicide defines denial of family planning services as a form of sexual, gender-based violence
<i>Promotes a tailored approach to serving adolescents</i>				
Do policies recognize that the family planning needs of young women vary by marital status?	X			The National Family Planning Guidelines note that unmarried adolescents are a special group needing counseling
Do policies recognize that, within the 15–19 age group, family planning needs vary by age?		X		The K'atun National Development Plan recognizes differences in the 15–19 age group; other policies, however, generally do not recognize differences by specific age; several policies promote a differential approach for those ages 10–14
Do policies promote a differentiated, tailored approach to providing services to adolescents?	X			Safe Motherhood Law; K'atun National Development Plan; National Plan to Prevent Adolescent Pregnancy; Public Policy to Protect Childhood and Adolescence; Adolescent and Youth Health Policy; National Family Planning Guidelines
<i>Addresses contextual factors</i>				
Do policies address how men and boys can support family planning use by adolescent women?	X			National Plan to Prevent Adolescent Pregnancy
Do policies view access to family planning services by adolescents as requiring a multisectoral approach?	X			National Youth Policy; National Plan to Prevent Adolescent Pregnancy
Are there policies that give girls the right to education and set mandatory education levels?	X			The Constitution mandates nine years of free education
Do policies address gender-based barriers to family planning use by adolescents?	X			National Plan to Prevent Adolescent Pregnancy; National Youth Policy
Do policies explicitly allow girls to remain in school should they become pregnant?			X	No policies exist
Do policies allow girls who have children to stay in school?			X	No policies exist
<i>Supports implementation</i>				
Do policies include mechanisms for accountability?		X		Only partially, because few mechanisms exist for civil society to monitor implementation of these policies

Element and sub-element	Yes	Partially	No	Comments
Is there consistency across policies, with policies not contradicting each other?		X		Mostly yes, but with some inconsistencies regarding age of consent for sex, rape, and access to family planning services; some inconsistency regarding age of consent
Are national statistics and data-reporting systems collecting and analyzing data disaggregated by sex, adolescent age, and marital status?	X			National survey includes questions for both married and unmarried adolescents; the country tracks adolescent pregnancies closely, especially for girls under 15
Does a budget line exist specifically for adolescent family planning services?			X	No budget line exists

Summary for Guatemala

Guatemala has a large population of adolescents, with significant proportions of its young women already married and having children before their 20th birthday. Educational attainment of young women has been improving steadily, and age at first marriage has risen slightly over time. Adolescent women have the lowest rates of contraceptive use, highest unmet need for family planning, and lowest levels of demand satisfied for family planning compared to older women. The policy environment for adolescent access to family planning is very supportive. It is particularly strong in relation to policies that support human rights, consent laws, and tailoring policies to the specific needs of adolescents. Multiple and reinforcing laws, policies, and guidelines contain language supporting adolescent access to information and services. However, gaps remain in the areas of adolescent-specific guidelines, international agreements, policies that address contextual factors such as access to education, and structures needed for effective policy implementation. Despite this strong policy framework, which is supported by active civil society groups, organized conservative groups are working to limit adolescent access to family planning services and information, including sexuality education.

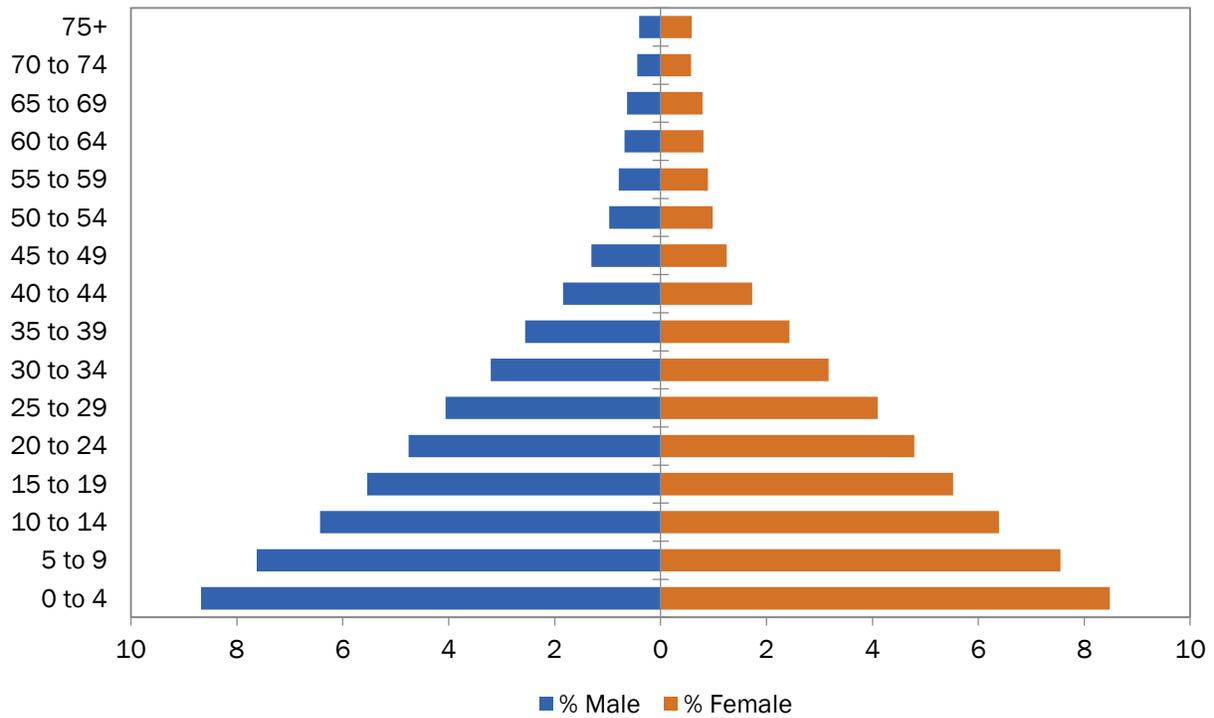
COUNTRY CASE STUDY: MALAWI

The Context for Young Women’s Lives in Malawi

Age structure of the population

Malawi has a very young population, with more than half under age 20 (Figure 16). Of Malawi’s total 2015 population of 17.2 million, 1.9 million were between ages 15–19, half of which are female—about 950,000 or about 5 percent of the total population.

Figure 16. Distribution of Population in Malawi, 2015

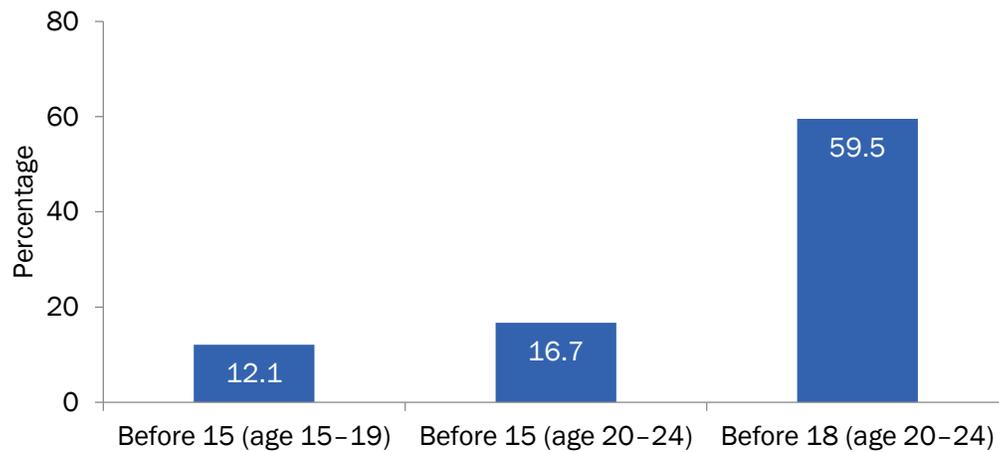


Source: United Nations, 2015

Age of sexual debut

Many young women in Malawi begin having sex at a very young age. By age 15, 17 percent of women ages 20–24 have begun having sex, and by age 18, 60 percent have had their sexual debut (Figure 17).

Figure 17. Women’s Age at Sexual Debut in Malawi

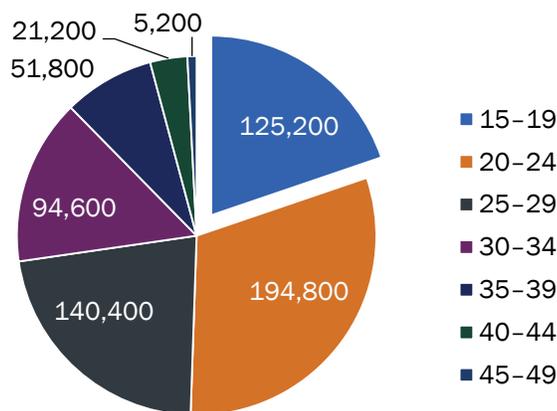


Source: Malawi Demographic and Health Survey (DHS) 2010 (NSO and ICF Macro, 2011)

Birth rates

Of the 633,000 babies born in Malawi each year, about 125,000 are born to adolescent girls, representing approximately 20 percent of all births in the country (Figure 18). Rates of adolescent childbearing in Malawi are high. The birth rate for women ages 15–19 in Malawi is 140 per 1,000, meaning that, on average, 14 percent of young women ages 15–19 give birth every year (NSO and ICF International, 2016).

Figure 18. Yearly Births in Malawi, by Age Group, 2015

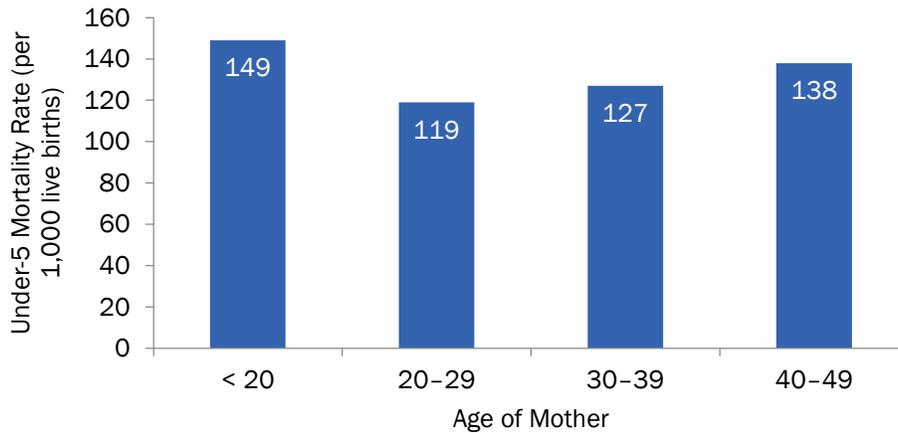


Source: United Nations, 2015

Child death rates

Compared to older women, mothers who give birth before age 20 have a much higher likelihood of having a child who will die by age 5 (Figure 19).

Figure 19. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Malawi

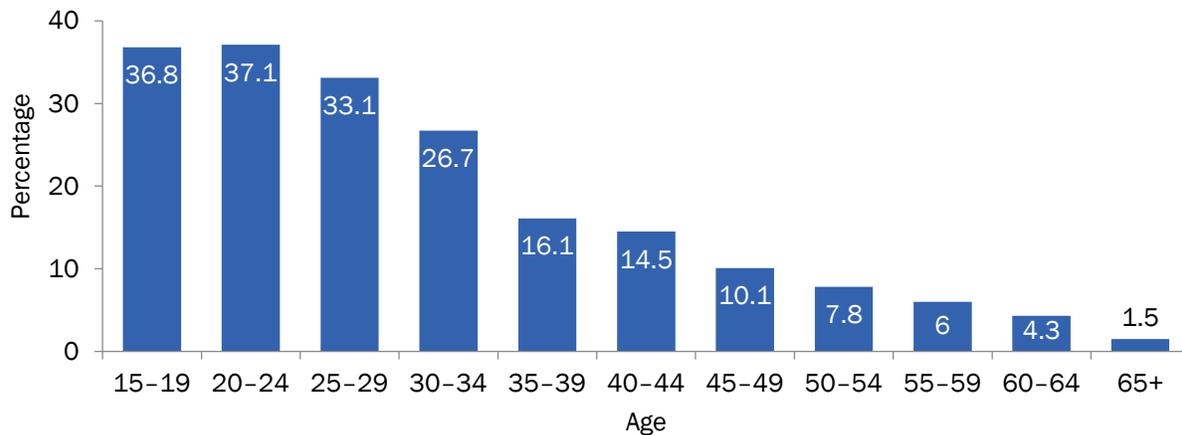


Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Educational attainment

Educational attainment in Malawi is still quite low, with many girls never attending school. Only 37 percent of young women ages 15–19 have completed at least a primary education (Figure 20). Notably, this percentage drops significantly in older age groups, meaning that **today's young** women have a better chance at education than did their mothers and grandmothers.

Figure 20. Women Completing Primary Education in Malawi

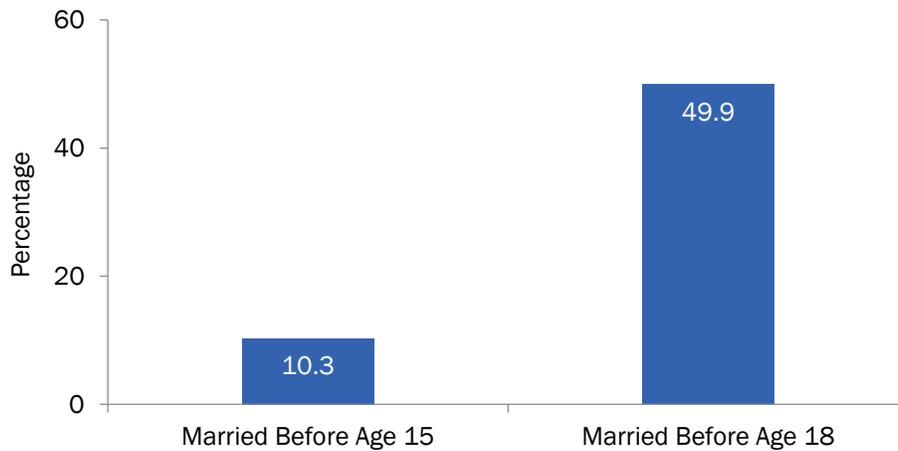


Source: Malawi DHS 2015–16 (NSO and ICF International, 2016)

Early or coerced marriage

Early marriage is common in Malawi. Approximately 10 percent of women marry before age 15 and half are married before age 18 (Figure 21). Far fewer men than women marry at such young ages. Further exacerbating the disadvantages young women face due to early marriage, their husbands are on average about 10 years older (NSO, 2015).

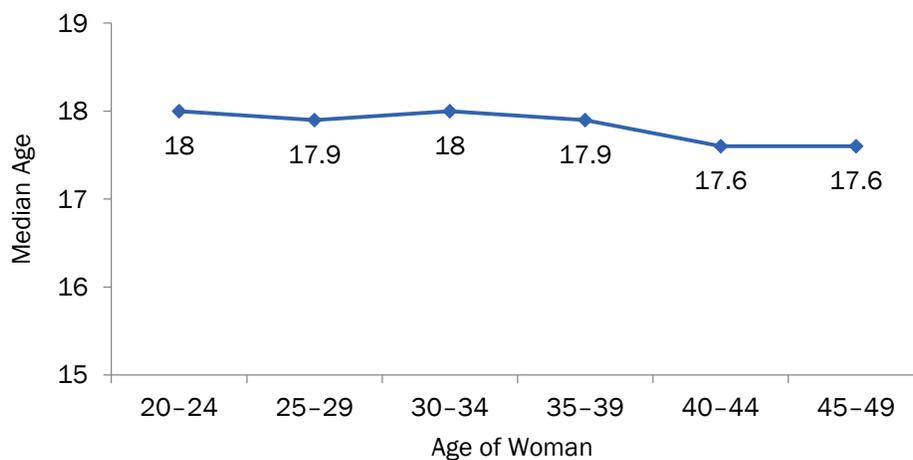
Figure 21. Early Marriage in Malawi (Women, Ages 15–49)



Source: Malawi MDG Endline Survey 2014 (NSO, 2015)

Age patterns of marriage have changed little over time, with the median age at first marriage for older women only about half a year less than for the youngest women (Figure 22).

Figure 22. Variation in Median Age at First Marriage over Time, Malawi

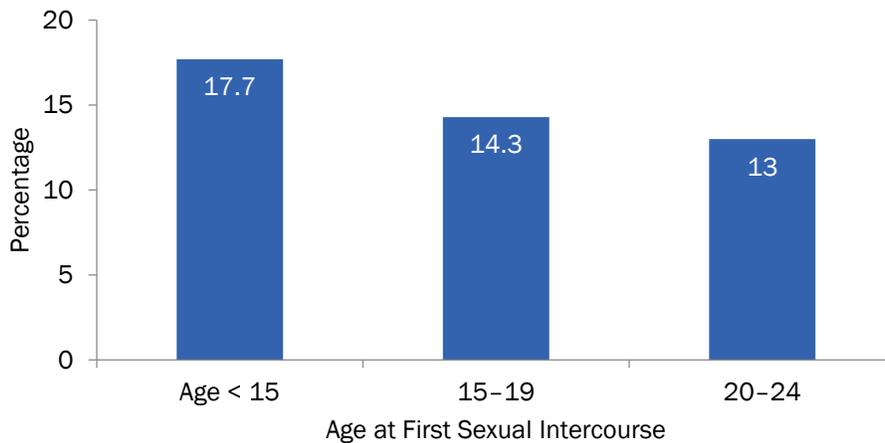


Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Violence against young women

For many young women in Malawi, their first sexual encounter is forced. The younger the age of first sexual intercourse, the greater the likelihood that it was forced (Figure 23).

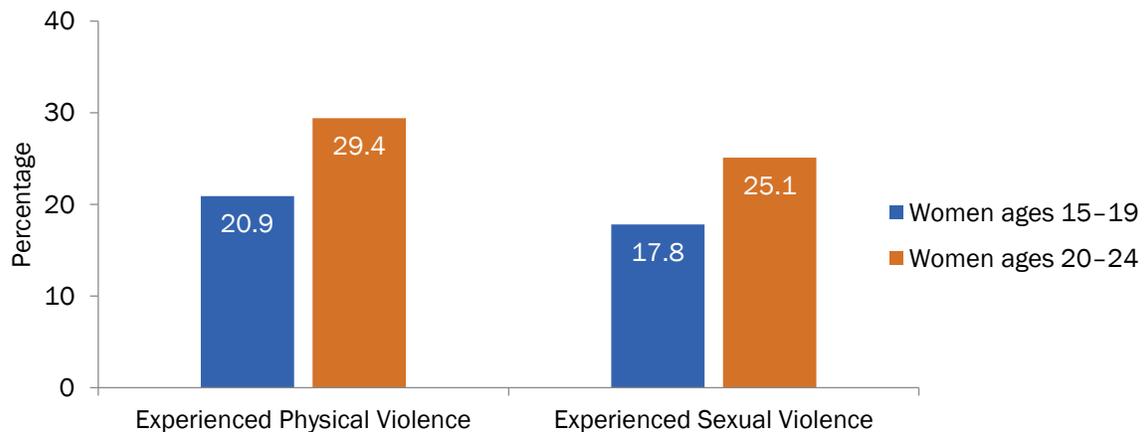
Figure 23. Forced Sexual Initiation in Malawi



Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Forced sexual initiation is only one of the forms of violence that young women in Malawi encounter. About 20 percent of those ages 15–19 in Malawi have experienced physical violence and about 18 percent have experienced sexual violence (Figure 24).

Figure 24. Young Women’s Experience with Physical and Sexual Violence, Malawi



Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

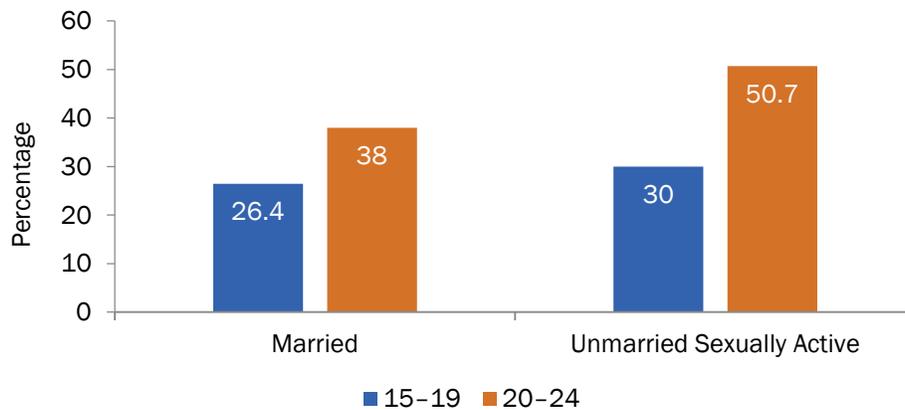
Female genital cutting

Only a few small groups in Malawi practice female genital cutting (UK Border Agency, 2008).

Contraceptive use

Approximately 26 percent of married women ages 15–19 use a modern method of contraception, a percentage significantly lower than for older women. Contraceptive use among unmarried, sexually active young women is higher, at about 30 percent, but also much lower than use in older women (Figure 25).

Figure 25. Use of Modern Contraception by Married and Unmarried Sexually Active Young Women, Malawi

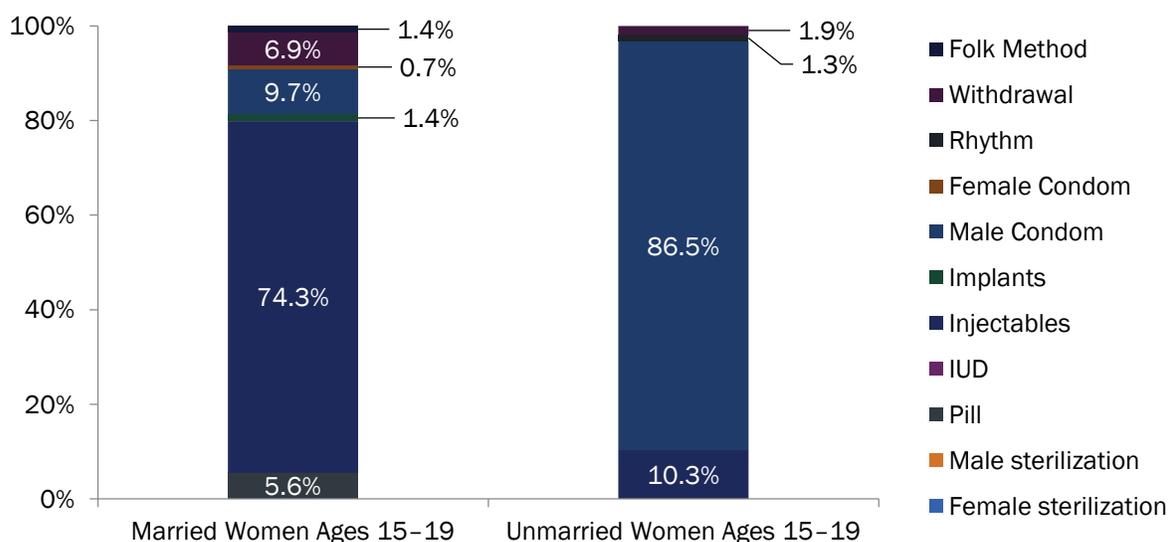


Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Contraceptive method mix

By far, the preferred method of family planning for married women ages 15–19 is the injectable contraceptive, accounting for three-fourths of all methods used by this group. Unmarried sexually active women of the same age have far different method preferences, with the vast majority (87 percent) choosing condoms (Figure 26).

Figure 26. Method Mix for Married and Unmarried Women Ages 15–19, Malawi

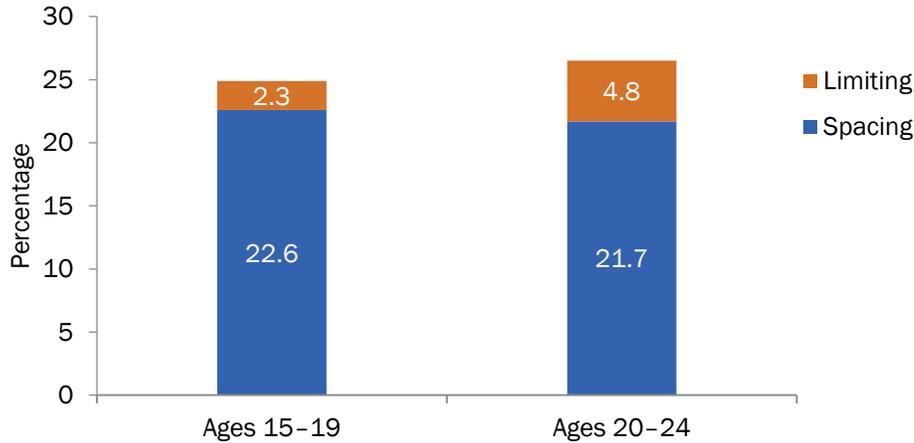


Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Unmet need for family planning

Unmet need for family planning is high in Malawi, at approximately 25 percent of married young women ages 15–19. The level is about the same for older women (Figure 27).

Figure 27. Unmet Need for Family Planning Among Married Women in Malawi

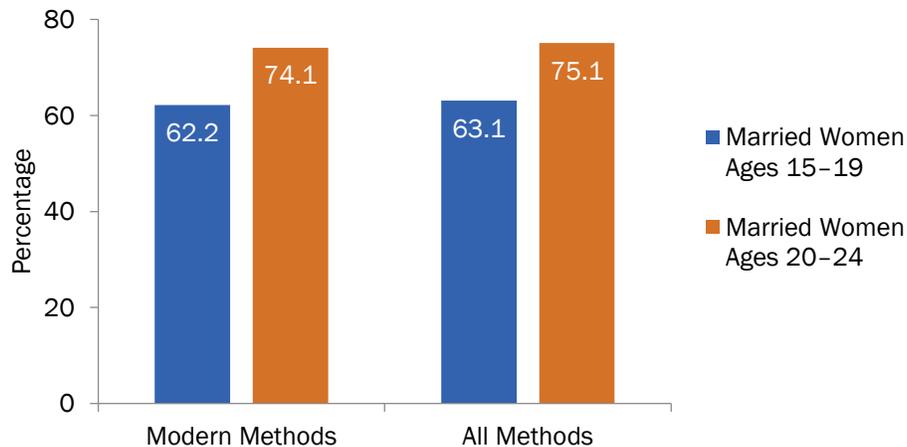


Source: Malawi DHS 2010 (NSO and ICF Macro, 2011)

Family planning demand satisfied

Young women ages 15–19 have approximately 60 percent of their demand for modern family planning satisfied, and a slightly higher level of their demand satisfied for all methods. These levels are only slightly lower than for older women (Figure 28).

Figure 28. Demand for Family Planning Satisfied in Malawi



Source: Malawi DHS 2015–16 (NSO and ICF International, 2016)

Accessing Family Planning Services: The Current Policy Environment for Young Women Ages 15–19 in Malawi

Malawi has a broad range of policies that influence access to family planning services by young women ages 15–19.

Laws, treaties, and conventions

The Constitution ensures the right to health. The Malawi Constitution obliges the state to ensure that all Malawians have free healthcare and other social services of the highest quality within the limited resources available. It also guarantees equality to all people in access to health services. However, the Constitution does not explicitly describe family planning or young women and makes no mention of differences between married versus unmarried women or girls. To the extent that it guarantees quality healthcare to all people, the Constitution has a positive impact on access to family planning for young women.

The Constitution discourages but does not outlaw child marriage. The Constitution states that no person shall be forced to enter into marriage and then outlines various provisions by age. Youth between ages 15–18 can be married only with the consent of their parents or guardians, whereas marriage of persons under age 15 is actively discouraged. **Malawi's** Sexual Rights Database notes that “religious law is respected and enforced in certain instances, notably in marriage and inheritance matters” (National Sexual Rights Law and Policy Database, n.d.). The effect of these provisions on family planning access and use is indirect but affects the context in which young people have sexual relations because it is often within marriages that have taken place during their adolescence.

The Constitution protects children from economic exploitation. The Constitution states that children (under age 16) are entitled to protection from exploitation. The policy ensures the protection of young women (ages 16 and below) from sex work. It does not distinguish among them based on marital status.

The Penal Code sets the age of sexual consent at 16 but does not mention boys. The code does not differentiate between married versus unmarried girls, although the Constitution states that youth ages 15–18 can be married with parental consent. The law may negatively affect family planning access for young unmarried women. Should an unmarried woman under 16 be sexually active (consensually), she may be less likely to seek health services if her partner might face charges.

The Penal Code minimally outlaws the abduction of girls under 16. The law defines abducting an unmarried girl under 16 as a misdemeanor. The law protects unmarried women only. The impact on access to family services is minimal, though the policy seeks to preserve the safety of young unmarried women.

The Penal Code outlaws procuring women under 21 for sex work. Although the law prohibits procuring/attempting to procure a girl or woman under the age of 21 for sex or sex work, the impact on access to and use of family planning services is likely minimal.

The Penal Code criminalizes some aspects of sex work. According to the Sexual Rights Database, “There is no law penalizing the sale of sexual services in Malawi, but some aspects of sex work are criminalized, such as ‘living on the proceeds of sex work.’” **Other provisions of the code use** vague language, such as “rogue and vagabond,” which are open to broad interpretation and negatively affect female sex workers (often used to justify arrest). The law could affect family

planning access or use because if living on the sale of sexual services is criminalized, a young woman in sex work may be less likely to seek services. The law does not differentiate between married and unmarried women.

The Penal Code allows abortion only to save the life of the woman. The code generally outlaws abortion and prescribes imprisonment for abortion providers and women seeking abortion. The law makes an exception in a case wherein the life of the mother is endangered. The law applies to all women, regardless of age and marital status. Strict policies, allowing for abortion only when the mother's health is in danger, may encourage the use of family planning services by sexually active young women wishing to avoid unintended pregnancy.

The 2013 Gender Equality Act guarantees access to reproductive healthcare and bars discrimination in providing services based on marital status. This law aims to promote gender equality, specifically, equal integration, influence, empowerment, dignity, and opportunities for men and women in all areas of society. It also prohibits and provides redress for sex discrimination, harmful practices, and sexual harassment. Finally, it provides for public awareness on the promotion of gender equality and related matters. This law is likely to have a very positive impact on access to and use of family planning by adolescents. Although it does not explicitly mention youth or adolescents, it includes language guaranteeing reproductive health services to all persons, and its provisions bar health workers from discriminating based on marital status or spousal consent.

The 2015 Marriage, Divorce and Family Relations Act raised the minimum legal age of marriage to 18. Parliament voted unanimously to pass this bill in February 2015, and the President signed it into law in April 2015. Essentially, the law bans child marriage by raising the minimum legal age of marriage from 15 to 18 for all statutory and customary marriages. It also explicitly acknowledges the negative health implications of early marriage for young women. However, Parliament must change the Constitution for the law to be properly upheld. If implemented, this law has the potential to have a strong impact on the rights and protections of young women. It recognizes the important barriers young women face, stating that “in the case of the girl child, marriage under the age of eighteen years of age is a health hazard; early marriage also has negative development implications.”

Malawi is signatory to all relevant international treaties and conventions. Malawi is signatory to major international treaties and conventions, including the Universal Declaration of Human Rights, 1948; the 2000 Millennium Declaration (Millennium Development Goals [MDGs]); the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium; the Abuja Declaration, which calls on African governments to increase their budgetary allocations to health to at least 15 percent; the Paris Declaration on Aid Effectiveness; the Accra Agenda for Action; the Busan Partnership for Effective Development Cooperation; the African Union Maputo Plan of Action on Sexual and Reproductive Health and Rights; FP2020 Commitments; the Sustainable Development Goals; the Convention on the Elimination of Discrimination Against Women, 1979; International Conference on Population and Development, 1994; the Convention on the Rights of the Child, 1989; the Social Development Summit, 1995; and the Beijing Platform of Action, 1995.

Policies, plans, and strategies

The 2011–2016 Health Sector Strategic Plan says relatively little about adolescents. The plan guides the efforts of the Ministry of Health and all stakeholders in contributing to the attainment of the Malawi Growth and Development Strategy II and the MDGs. It acknowledges the need to increase family planning use and address unmet need for contraception. However, it

lacks a clear emphasis on adolescents. The plan does set a high-level objective of focusing on populations “such as adolescents seeking sexual and reproductive health and post-abortion-care” but does not operationalize strategies or next steps. The plan does not formally define adolescents. It is likely to have little effect on family planning access for adolescents because of its lack of a clear emphasis on them. Moreover, the plan does not differentiate between married versus unmarried women of any age.

The Malawi Growth and Development Strategy II (MGDS-II) 2011–2016 addresses some adolescent-specific concerns. The MGDS-II lays out principles to inform Malawi’s future and set policy priorities. Some of these priorities are relevant to family planning and youth. Under the social development theme, the document recognizes the importance of integrating population variables in development planning. Suggested policies make specific reference to youth-friendly health services. The MGDS-II also identifies several key priority areas, in addition to thematic areas, which include public health and youth development and empowerment. The document lays out future policies and activities aimed at managing population growth, including enhancing the provision, access, delivery, and utilization of sexual and reproductive health services; advocating for **girls’ education and delayed marriage**; and promoting the small family concept. **The strategy’s overall impact on family planning access is likely to be positive because of its multisectoral approach and support for issues such as girls’ education and delayed marriage.** It also specifically mentions the need to invest in youth-friendly health services for reproductive health.

The MGDS-II also promotes access to education. This strategy acknowledges the need to improve access to quality and relevant education, including “providing a conducive environment for **girls’** education, including boarding facilities.” The policy does not directly affect access to family planning but speaks to issues related to family planning access/rights. It does not distinguish between married versus unmarried girls. As mentioned above, the overall value of this multisectoral document is that it acknowledges the need for enhancing the provision, access, delivery, and utilization of sexual and reproductive health services, and advocating for **girls’** education and delayed marriage.

The 2009 National Sexual and Reproductive Health and Rights (SRHR) Policy highlights young people as one of its policy themes. Overall, the policy aims to provide accessible, affordable, and convenient comprehensive reproductive health services to all women, men, and young people in Malawi. It stresses the integration of sexual and reproductive health services into routine care. One of its policy themes is that of young people in reproductive health, highlighting services **including** “family life education; provision of family planning services to all women, regardless of parity and marital status; ensuring that quality family planning services are accessible and convenient at all levels; ensuring reproductive rights of all individuals; ensuring that family planning and reproductive health services are male, youth and young adolescent (ages 8–14) friendly; and encouraging delay of the first pregnancy and condom use” (National Sexual Rights Law and Policy Database, n.d.). The policy does not formally define youth or adolescence or differentiate between married and unmarried adolescents. Overall, this policy is beneficial for family planning access for young women, as it makes specific reference to “young people.” By not specifying that only married women should have access, but all couples, it allows access for all adolescents.

The 2009 National SRHR Policy does not require parental consent for sexually transmitted infection (STI) services. By ensuring confidentiality and not requiring parental consent for STI services, young unmarried women are more likely to seek these services. Notably, the policy does not differentiate between young married versus unmarried women.

The 2009 National SRHR Policy mandates access to youth-friendly services. The policy specifically calls for all young people, regardless of marital status, to have access to youth-friendly health services. The policy does not differentiate between young married/unmarried women. However, it does vow to “guard privacy” and “respect cultural values and religious beliefs.” By ensuring access, quality, and confidentiality, and by stressing youth-friendly health services at all levels of care, young women are more likely to seek these services, including family planning.

The 2009 National SRHR Policy specifically opposes harmful practices, such as female genital cutting and domestic violence. In its language on harmful practices, the policy specifically mentions young people but does not differentiate by marital status. An emphasis on reducing these harmful practices should have a direct impact on access to and use of family planning by those ages 15–19 by reducing the negative health impacts associated with these practices and giving young women greater autonomy in their access to healthcare, including family planning.

The 2009 National SRHR Policy minimally promotes male involvement. In addressing male involvement, the policy specifically mentions young people but does not differentiate by marital status. In alignment with many clinical guidelines, the policy seeks to promote the shared responsibility of parenthood and sexual and reproductive health services, which may benefit young married women.

The National Sexual and Reproductive Health and Rights Strategy (SRHRS) 2011–2016 specifically calls for strengthening services for young people. The Ministry of Health’s SRHRS 2011–2016 is a revised version of the first reproductive health strategy 2006–2010. The SRHR policy and strategy underpins Malawi’s commitment to the achievement of MDGs 3, 4, and 5, and identifies priority actions to reach MDG targets and improve Malawians’ sexual and reproductive health outcomes. The Malawi Government believes that individuals and couples have the right to equitable access to comprehensive, high-quality sexual and reproductive health services that meet the needs of clients, and that the use of these services is a critical factor in the socioeconomic development and well-being of every Malawian—especially women, newborns, and adolescents. The strategy includes an entire chapter dedicated to adolescents and youth, which sets out two strategic objectives: strengthening access to and utilization of quality youth-friendly health services, and strengthening research on reproductive health knowledge and attitudes in young people. The strategy does not distinguish between married and unmarried adolescents. The strategy should increase access to and use of family planning by adolescents.

The 2012 National Population Policy supports youth-friendly reproductive health services. The policy’s focus is on slowing the country’s unsustainably high rate of population growth through voluntary and quality family planning services. The policy recognizes the need for activities aimed at empowerment and education for women, youth-friendly reproductive and health services, and delayed entry into marriage and parenthood. It does not define youth or adolescent, and does not differentiate between married and unmarried adolescents.

The 2011–2016 National HIV and AIDS Policy supports provision of information and services to youth. This document, which lays out the national policy on HIV/AIDS, seldom mentions adolescents and youth but is likely to have a positive impact, given the statement on services and information for youth. It does not mention family planning provision.

The 2015–2020 National HIV Prevention Strategy strongly promotes actions to address adolescent and youth HIV transmission. This National AIDS Commission document is the guiding tool for designing and implementing evidence-based, rights-sensitive, and targeted HIV prevention interventions that support the achievement of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 treatment targets as adopted in the revised 2015–2020

National HIV and AIDS Strategic Plan. It specifically identifies young women ages 10–24 as a key population group for prevention activities. The policy is likely to have an indirect positive impact on adolescent access to family planning services because of the specific emphasis on strengthening youth-friendly health services and the general way in which it recognizes the uniqueness of the adolescent and youth population.

The 2015–2020 National SRHR and HIV and AIDS Integration Strategy recognizes youth as a priority group for intervention. This Ministry of Health-authored strategic plan aims to facilitate the integration of SRHR and HIV and AIDS programming in Malawi. Although it does not explicitly define adolescent and youth, it refers to the 15–24 age group. It does not distinguish between married and unmarried adolescents. The strategy is likely to have a positive impact because of the recognition of youth as a priority age group.

The 2008–2012 National Plan of Action for Scaling up Sexual and Reproductive Health and HIV Prevention Initiatives for Young People lays out a comprehensive plan to improve services for youth. The purpose of this Ministry of Youth plan was to pull together and harmonize all of the major initiatives to prevent HIV within the framework of the Paris Declaration and the MGDS. Its six strategic objectives address a range of activities for strengthening access to SRHR and HIV services and information for youth ages 10–24. The policy should have had a very positive impact on access to family planning services and information for adolescents.

The 2013 National Youth Policy strongly supports actions to allow adolescents access to healthcare, including family planning. The policy, which defines youths as ages 10–35, lays out seven focus areas, of which education for youth and youth health and nutrition are the most relevant to family planning. The health and nutrition policy ensures that “comprehensive SRHR and HIV prevention information, services and life skills to in and out of school youths is promoted and sustained.” Adolescent girls and teenage parents are both listed as priority target populations.

The 2013 National Youth Policy also encourages girls to continue their education after giving birth. Under the education policy area, the document cites the following strategy: “encourage girls to go back to school after giving birth.” It emphasizes abstinence, but the wording does allow for other contraceptive methods.

The 2015–2020 National Youth-Friendly Health Services Strategy provides a comprehensive policy basis for giving young women access to family planning. The strategy, which defines youth as people ages 10–24, aims to encourage high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people. The strategy calls for services in line with the minimum health package, with the aim of increasing acceptability and use of health services by young people.

The 2008–2017 National Education Sector Plan provides overarching support to primary and secondary education, with an emphasis on girls’ education. The plan “sets out the Government’s view of Malawi’s education sector goals, objectives and proposals on how such goals and objectives will be realized over the coming decade (2008–2017).” Although the policy does not mention sexual and reproductive health, family planning, or sexuality education as part of the health curriculum, if implemented, the overall impact on access should be positive, given the links between girls’ education and access to and use of family planning services, delay of sexual debut, and delay of marriage and first birth. Regarding health, the plan prioritizes integration of HIV/AIDS awareness into school curricula.

The School Readmission Policy encourages girls to return to school after pregnancy and childbirth. This policy clarifies procedures for withdrawal and readmission in light of “problems

surrounding the implementation” of the original school readmission policy introduced in 1993. Specifically, it outlines the “withdrawal process for a pregnant schoolgirl,” the “withdrawal process of a boy responsible for a pregnancy of a schoolgirl,” and “re-admission process of students who withdraw on pregnancy grounds.” Under the policy, both girls and boys must withdraw for one year with an opportunity for readmission available once every education cycle. Counseling on withdrawal and readmission is mentioned, but does not specifically discuss family planning services. These clarified procedures reinforce that women and men should be encouraged to return to school after giving birth/fathering a child. In this way, the policy positively affects women’s rights and opportunities. However, in not explicitly encouraging family planning counseling, it does not have a direct impact on access to or use of family planning services.

The 2015 National Gender Policy articulates the need to increase access to family planning for young women and adolescents. The policy aims to reduce gender inequalities and enhance participation of women, men, girls, and boys in socioeconomic development processes. The Ministry of Gender, Children and Social Welfare coordinates its implementation, with different sectors responsible for various objectives. It does not include a detailed discussion of family planning and reproductive health strategies, but notes among its priority concerns and gaps a need for increased male involvement and suggests that the current large family size is a result of family planning interventions designed primarily to target women only. It also states that the policy will ensure that “women, men, girls and boys and other vulnerable groups have access to quality sexual and reproductive health services.” The policy does not explicitly define youth, yet articulates the need to increase access to family planning for young women and adolescents. The policy does not distinguish between married and unmarried women in its discussion of family planning but discusses the need to address power imbalances in marriages and involve men in reproductive health and family planning. The policy provides a good starting point for various ministries to implement strategies to accomplish the objectives it lays out. That said, the overall policy functions on a high level and is thin on specific details and planned steps.

Operational policies, standards, and guidelines

The 2007 National Standards for Youth-Friendly Health Services set guidelines for broad improvement in health services for adolescents. These standards focus on improving the youth friendliness of clinical services in line with the defined essential package of health services. They encourage service providers to foster a supportive environment for youth-friendly services, increase service use and participation by communities and youth, increase acceptable and accessible youth-friendly services, provide information on health and rights to health services to youth, and include contraceptive services/family planning service provision at various facility levels. Although the standards do not define youth explicitly, the background section includes data and information on young people ages 15–24. If implemented, the standards would directly affect family planning access for adolescent girls. Although lacking in detail on family planning, the standards focus on the entire health service package, emphasizing ways service providers can improve service delivery, service quality, and skills. The standards do not differentiate between married versus unmarried girls.

The 2010 Preservice Education Family Planning Reference Guide provides clear guidance on addressing the family planning needs of adolescents. The guide assists preservice health institutions in Malawi in creating, updating, or adapting the family planning content of their curricula and individual courses. The guide includes a module on providing family planning for adolescents, including medical criteria for adolescent use of various methods. The module clearly states that adolescents are medically eligible to use any method of contraception and must have access to a variety of contraceptive choices.

The 2001 National Reproductive Health Service Delivery Guidelines specifically address adolescent needs. Malawi's guidelines provide detailed guidance for public and private sector service providers as a basis for comprehensive, high-quality, and standardized care. The guidelines include a chapter specifically addressing adolescents and the characteristics of adolescent-friendly services.

The 2005 Guidelines for the Management of Sexual Assault and Rape in Malawi include specific instructions on dealing with children and adolescents. These Ministry of Health guidelines aim at improving Malawi's health services for all individuals (women, men, and children) who have been victims of sexual assault. They include chapters on addressing child sexual assault.

The 2008 Community-Based Injectable Contraceptive Service Guidelines encourage youth involvement. The guidelines encourage the scale-up of community delivery of injectables through training health surveillance assistants to provide them. Although the guidelines do not mention youth specifically, adolescent girls benefit by the guidelines promoting increased access to an expanded method mix and choice. Moreover, the guidelines encourage the formation of youth groups to engage in dialogue on family planning and HIV. They also encourage male involvement through couples counseling, which could benefit young married women. The guidelines do not differentiate between married and unmarried girls or women.

The 2007 Guidelines for Community Initiatives for Reproductive Health encourage participation of youth in program design. The guidelines outline actions to provide a standardized method of implementing community interventions for reproductive health to accelerate the reduction of maternal and neonatal mortality. Actions include increasing access to and use of family planning services. The guidelines do not specifically address youth but mention the need to include boys and girls ages 15–24 in focus group discussions for intervention design. The impact on adolescents' access is indirect, in that the guidelines mean to improve health outcomes for all women of reproductive age. Including young women in the intervention design process could help tailor solutions to the adolescent age group, including how to address access by married versus unmarried women.

The 2011 Guidelines for Family Planning Communication include discussion of techniques to overcome barriers to serving youth. The guidelines are a framework for implementing family planning communication programs, intended to ensure collaboration of all implementing partners. The guidelines identify key issues such as early childbearing; including adolescent girls and boys as target audiences and in target groups; including both in- and out-of-school youth; and identifying barriers youth face in accessing family planning services, such as negative provider attitudes, stigma surrounding family planning use, and lack of knowledge of family planning and how to prevent pregnancy. The guidelines do not specifically differentiate between married and unmarried adolescents. However, as an example of action to promote family planning for youth, the guidelines mention that, if a couple has recently married, they should talk about the benefits of timing the birth of their first child to ensure the health of both mother and child.

The 2009 Sexual and Reproductive Health Advocacy and Communication Strategy includes a focus on increasing access to youth-friendly services. The strategy aims to guide systematic and strategic programming in advocacy and communication for SRHR at all service delivery points. It neither defines youth nor distinguishes between married and unmarried young women. Because of its aims to increase access to youth-friendly health services, increase men's participation, address gender relations, and reduce the vulnerabilities of women and girls, the strategy should have a positive impact on access to family planning services.

Summary of the policy environment in Malawi

This assessment applied the framework discussed earlier to gauge the extent to which Malawi has a policy environment supportive of family planning access for young women ages 15–19. Malawi received an overall grade of “highly supportive,” based on a score of 92.4 out of a possible 100 points (Figure 29). Malawi’s policy environment is consistently either “very supportive” or “highly supportive” across all six main policy elements.

Figure 29. Grade for Policy Environment in Malawi, by Main Element

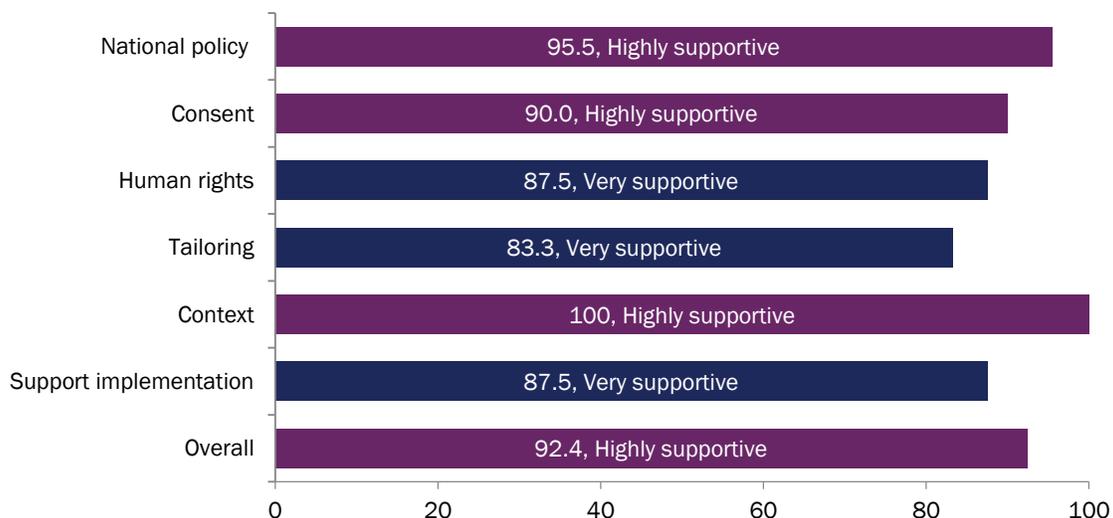


Table 2 shows the scoring breakdown by main element and individual sub-element. In the category of creating and ensuring the establishment of a national policy for adolescents, multiple policies often support adolescent-specific information and services. Only for post-abortion care is the current policy environment partially unsupportive. The consent element of the framework shows a gap in the area of age-related medical eligibility guidelines. For the human rights element, consistency in policies around age at marriage is an area needing improvement. When it comes to promoting a tailored approach, there is room for improvement in recognizing the differences within the 15–19 age group. Malawi received a perfect score on contextual factors. On implementation support, Malawi also did well, lacking only a specific budget line for adolescent family planning.

Table 2. Assessment of Policy Environment in Malawi, by Main Element and sub-Element

Element and sub-element	Yes	Partially	No	Comments
<i>Creates or ensures the establishment of a national policy on family planning for adolescents</i>				
Is there a policy that directly addresses provision of family planning to adolescents?	X			National Youth-Friendly Health Services Strategy 2015–2020
Are there specific family planning clinical guidelines for serving adolescents?	X			National Reproductive Health Service Delivery Guidelines; Community-Based Injectable Contraceptive Service Guidelines 2008; Guidelines for Family Planning Communication

Element and sub-element	Yes	Partially	No	Comments
Is there a policy that supports age-appropriate sexual and reproductive health education and information?	X			National SRHR Policy 2009; National Youth Policy 2013
Do policies promote the establishment of adolescent-friendly health services?	X			National Youth-Friendly Health Services Strategy 2015–2020; the National SRHR Policy 2009 mandates access to youth-friendly services; National SRHR 2011–2016; National Youth Policy 2013; Sexual and Reproductive Health Advocacy and Communication Strategy 2009
Is there a policy that provides adolescents with access to family planning post sexual assault?	X			Guidelines for the Management of Sexual Assault and Rape in Malawi 2005
Is there a policy that ensures there are no missed opportunities for appropriate integration of family planning with post-abortion care?		X		2011–2016 Health Sector Strategic Plan
Is there a policy that links provision of family planning to adolescents to broader family planning policies?	X			National SRHR Policy 2009; National SRHR 2011–2016; National Reproductive Health Service Delivery Guidelines
Is there a policy that links provision of family planning to adolescents to broader health policies?	X			National Plan of Action for Scaling Up Sexual and Reproductive Health and HIV Prevention Initiatives for Young People 2008–2012; National SRHR and HIV and AIDS Integration Strategy, 2015–2020; the 2011–2016 Health Sector Strategic Plan says relatively little about adolescents
Is there a policy that links provision of family planning to adolescents to broader adolescent development policies?	X			National Population Policy 2012; National Youth Policy 2013
Is there a policy that links provision of family planning to other national development plans and documents?	X			The MGDS-II 2011–2016 addresses some adolescent-specific concerns
Is the country signatory to key international agreements that support adolescent access to family planning information and services?	X			Malawi is signatory to all major international agreements and treaties
<i>Ensures that consent policies and unnecessary age or marital status restrictions are not a barrier to family planning use by adolescent women</i>				
Do all policies eliminate parental consent as a prerequisite for adolescents to use family planning services?	X			The National SRHR Policy 2009 eliminates parental consent for STI services

Element and sub-element	Yes	Partially	No	Comments
Do all policies eliminate spousal consent as a prerequisite for adolescents to use family planning services?	X			The Gender Equality Act of 2013 bars discrimination in providing services based on spousal consent; National SRHR Policy 2009
Are policies consistent with the latest WHO guidelines on medical eligibility criteria for contraceptive use as they relate to adolescents?		X		National Reproductive Health Service Delivery Guidelines; Preservice Education Family Planning Reference Guide
Do all policies eliminate consent requirements (age, parental, spousal) as a prerequisite for adolescents to use emergency contraception?				Per the International Consortium for Emergency Contraception, cecinfo.org, no information available
Do all policies eliminate marital status as a prerequisite for adolescents to use family planning services?	X			The Gender Equality Act of 2013 bars discrimination in providing services based on marital status; National Youth-Friendly Health Services Strategy
Do policies set an appropriate age of consent for sex?	X			The Penal Code sets the age of sexual consent at 16
<i>Promotes human rights</i>				
Do laws and policies prohibit marriage to women younger than 18?		X		Although the Marriage, Divorce and Family Relations Act raises the minimum legal age of marriage to 18, the Constitution discourages but does not outlaw child marriage; National Youth Policy
Do laws and policies exist that discourage the practice of female genital cutting?	X			The National SRHR Policy 2009 specifically opposes harmful practices such as female genital cutting and domestic violence
Do policies exist that promote programs to reduce the incidence of female genital cutting?	X			National SRHR Policy 2009
Do policies exist that promote programs to reduce the incidence of gender-based violence?	X			The National SRHR Policy 2009 specifically opposes harmful practices such as female genital cutting and domestic violence
<i>Promotes a tailored approach to serving adolescents</i>				
Do policies recognize that the family planning needs of young women vary by marital status?	X			National Youth-Friendly Services Strategy
Do policies recognize that, within the 15–19 age group, family planning needs vary by age?		X		The National Youth-Friendly Services Strategy notes differences by early, middle, and late adolescence but provides no specific approaches by age group

Element and sub-element	Yes	Partially	No	Comments
Do policies promote a differentiated, tailored approach to providing services to adolescents?	X			National Reproductive Health Service Delivery Guidelines; National Youth-Friendly Services Strategy
<i>Addresses contextual factors</i>				
Do policies address how men and boys can support family planning use by adolescent women?	X			The National SRHR Policy 2009 promotes male involvement
Do policies view access to family planning services by adolescents as requiring a multisectoral approach?	X			National Population Policy 2012
Are there policies that give girls the right to education and set mandatory education levels?	X			National Education Sector Plan 2008–2017; National Population Policy 2012
Do policies address gender-based barriers to family planning use by adolescents?	X			National Youth Policy; National Gender Policy 2015
Do policies explicitly allow girls to remain in school should they become pregnant?	X			School Readmission Policy
Do policies allow girls who have children to stay in school?	X			School Readmission Policy; Youth Policy 2013
<i>Supports implementation</i>				
Do policies include mechanisms for accountability?	X			National Youth-Friendly Services Strategy
Is there consistency across policies, with policies not contradicting each other?	X			No big inconsistencies found
Are national statistics and data-reporting systems collecting and analyzing data disaggregated by sex, adolescent age, and marital status?	X			National survey includes questions for both married and unmarried adolescents
Does a budget line exist specifically for adolescent family planning services?		X		The National Youth-Friendly Services Strategy includes cost estimates, but no dedicated government budget line exists

Summary for Malawi

Like Guatemala, Malawi has a very young population, with a large proportion of adolescent women already married and having children. Educational attainment is still quite low, with progress relatively stagnant. Meanwhile, sexual and physical violence affect many young women. Contraceptive use is still relatively low; unmet need is high. The policy environment in Malawi is highly supportive of adolescent use of family planning. Supportive laws, policies, and guidelines are consistently in place across the six key elements that constitute the policy environment.

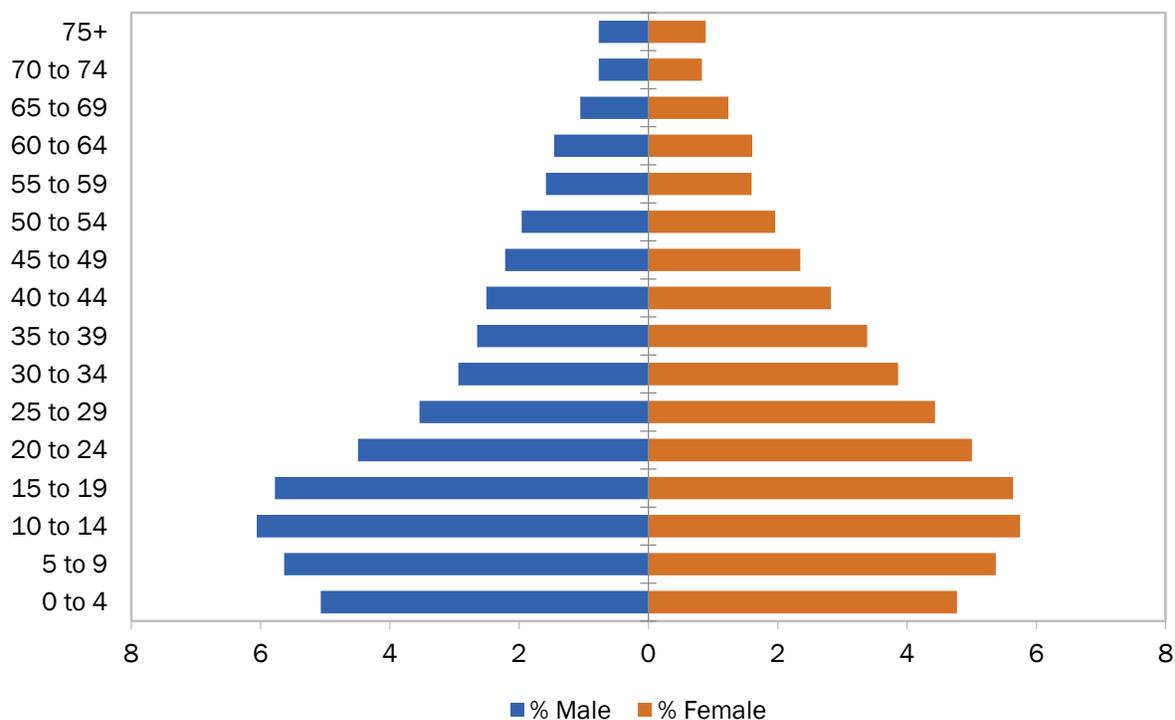
COUNTRY CASE STUDY: NEPAL

The Context for Young Women’s Lives in Nepal

Age structure of the population

Nepal has a young population, with 44 percent of the population under age 20 (Figure 30). Of Nepal’s total 2015 population of 28.5 million, 2.3 million are between ages 15 and 19.

Figure 30. Distribution of Population in Nepal, 2015

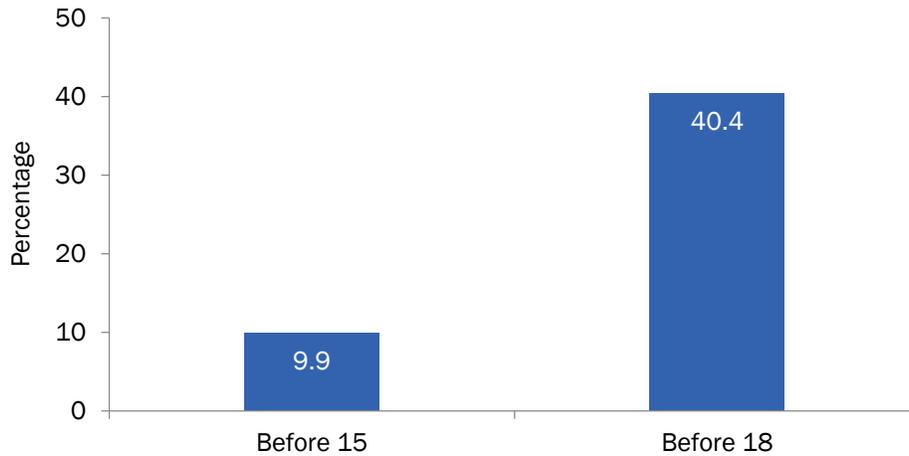


Source: United Nations, 2015

Age of sexual debut

Many young women in Nepal begin having sex at a very young age. By age 15, 10 percent of married women ages 20–24 have begun having sex; by age 18, 40 percent have had their sexual debut (Figure 31).

Figure 31. Women’s Age at Sexual Debut in Nepal (Married Women Ages 20–24)

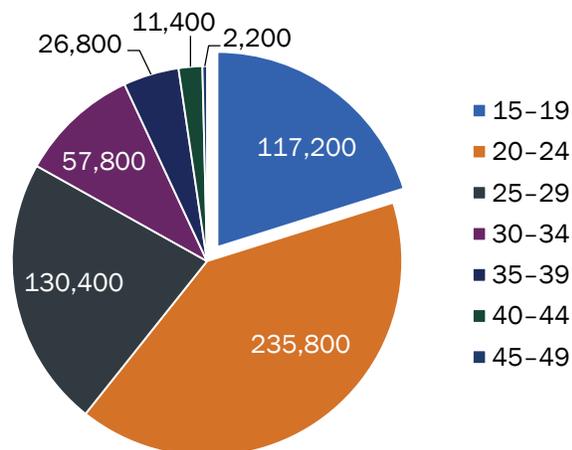


Source: Nepal DHS 2011 (MOHP et al., 2012)

Birth rates

Of the 581,000 babies born each year in Nepal, approximately 117,000 are born to adolescent girls, representing about 20 percent of all births in the country (Figure 32). The birth rate for women ages 15–19 in Nepal is 81 per 1,000, meaning that, on average, 8 percent of young women in this age group give birth every year (MOHP et al., 2012).

Figure 32. Yearly Births in Nepal, by Age Group, 2015

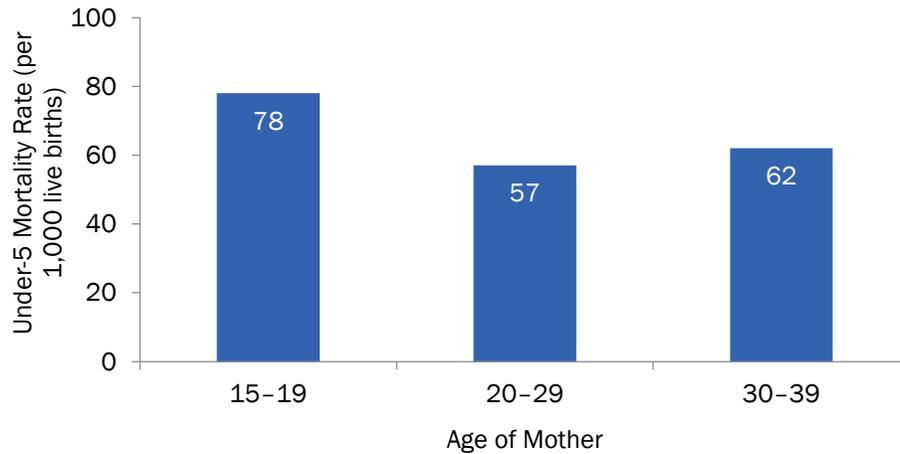


Source: United Nations, 2015

Child death rates

Compared to older women, mothers who give birth before age 20 have a much higher likelihood of having a child who dies by age 5 (Figure 33).

Figure 33. Mortality Rate for Children Under 5 of Mothers Ages 15–19 vs. Children of Older Mothers, Nepal

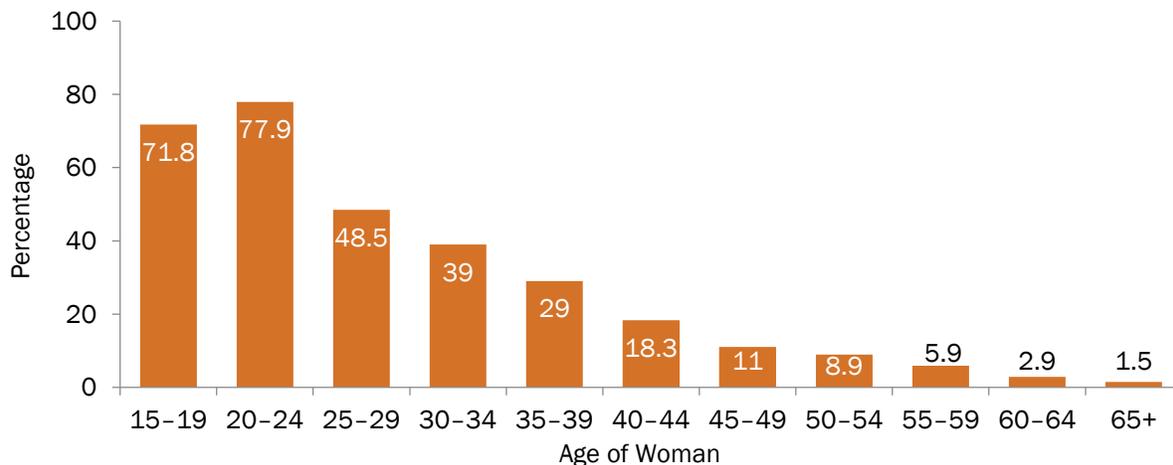


Source: Nepal DHS 2011 (MOHP et al., 2012)

Educational attainment

Approximately 72 percent of young women ages 15–19 have completed at least a primary education (Figure 34). Notably, this percentage drops significantly with older age groups, **meaning today’s young women have a better chance at education than did their mothers and grandmothers.**

Figure 34. Women Completing Primary Education in Nepal

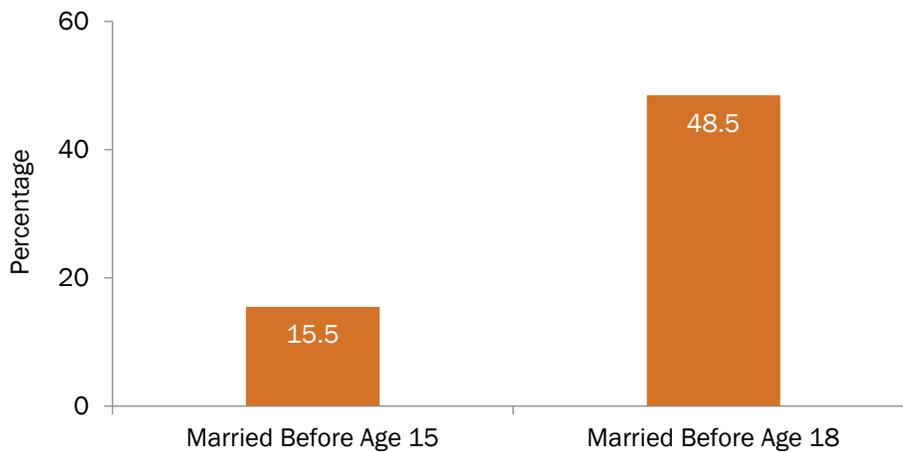


Source: Nepal DHS 2011 (MOHP et al., 2012)

Early or coerced marriage

Early marriage is common in Nepal. Of women ages 15–49, 16 percent marry before age 15, and almost half marry by age 18 (Figure 35).

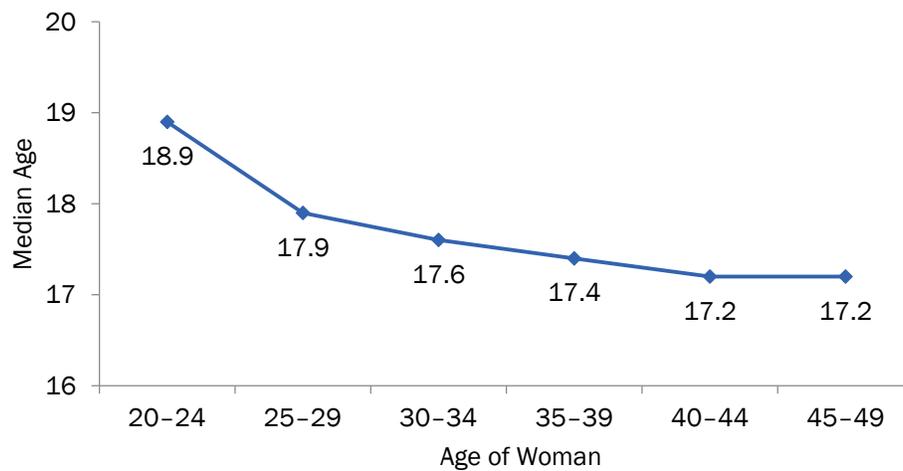
Figure 35. Early Marriage in Nepal (Women 15–49)



Source: Nepal Multiple Indicator Cluster Survey (MICS) 2014 (Central Bureau of Statistics, 2014)

The median age at first marriage has risen over time, from 17.2 years for women ages 45–49 to 18.9 for those ages 20–24 (Figure 36).

Figure 36. Variation in Media Age at First Marriage over Time, Nepal

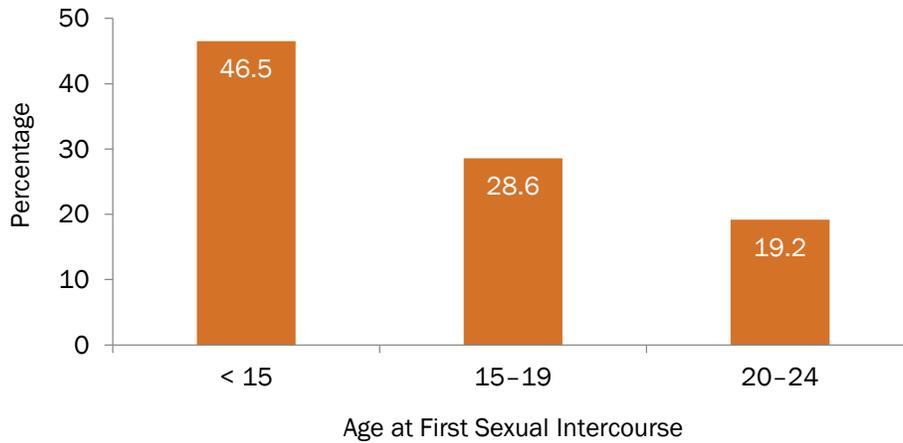


Source: Nepal DHS 2011 (MOHP et al., 2012)

Violence against young women

For many young women in Nepal, their first sexual encounter is forced. For 47 percent of those who were younger than 15 the first time they had sex, the experience was coerced (Figure 37).

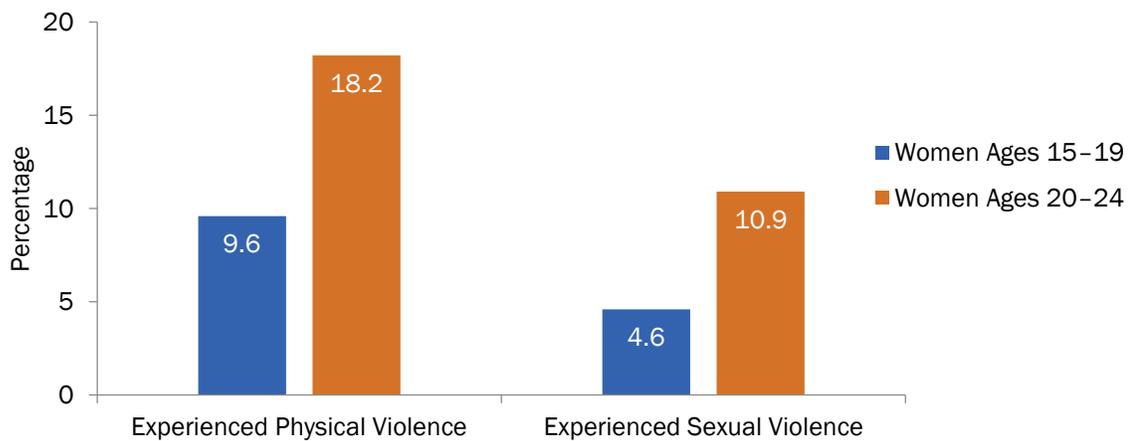
Figure 37. Forced Sexual Initiation in Nepal



Source: Nepal DHS 2011 (MOHP et al., 2012)

Significant proportions of young women in Nepal experience both physical and sexual violence (Figure 38).

Figure 38. Young Women's Experience with Physical and Sexual Violence, Nepal

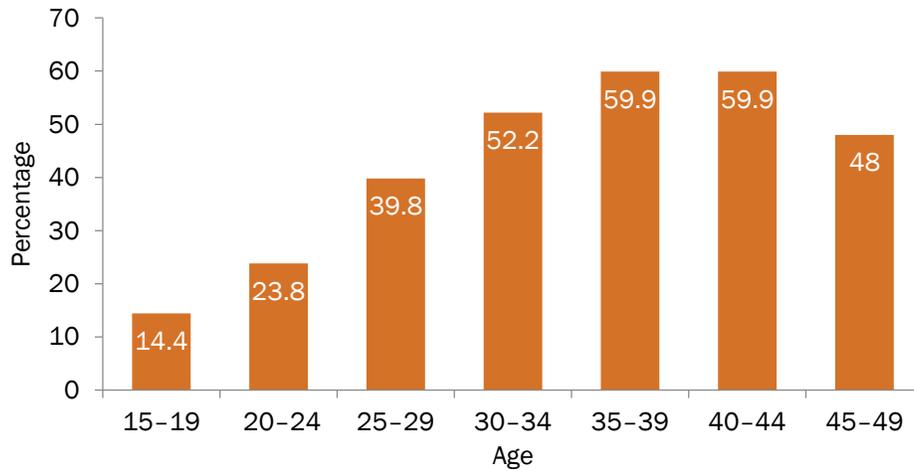


Source: Nepal DHS 2011 (MOHP et al., 2012)

Contraceptive use

Approximately 14 percent of married women ages 15–19 are using a modern method of contraception, a percentage significantly lower than for older women (Figure 39).

Figure 39. Use of Modern Contraception by Married Women, Nepal

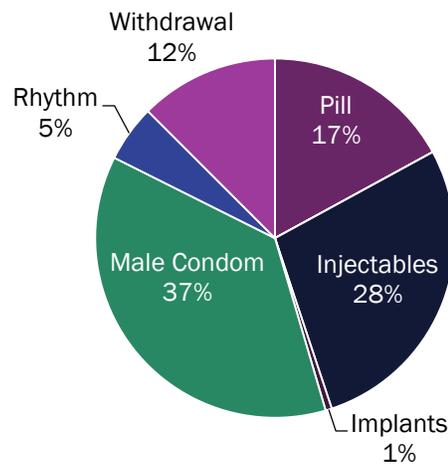


Source: Nepal DHS 2011 (MOHP et al., 2012)

Contraceptive method mix

Of those married young women ages 15–19 using contraception, the condom is their preferred method, accounting for 37 percent of all method use by this group (Figure 40).

Figure 40. Method Mix for Married Women Ages 15–19, Nepal

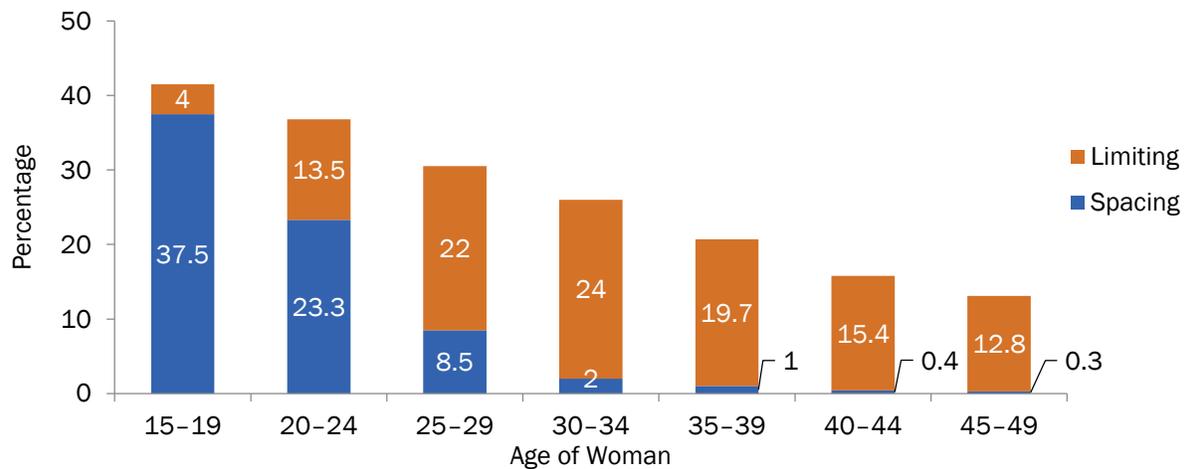


Source: Nepal DHS 2011 (MOHP et al., 2012)

Unmet need for family planning

Unmet need is high in Nepal, with 40 percent of married women ages 15–19 having an unmet need for family planning. The youngest women have the highest unmet need (Figure 41).

Figure 41. Unmet Need for Family Planning Among Married Women in Nepal

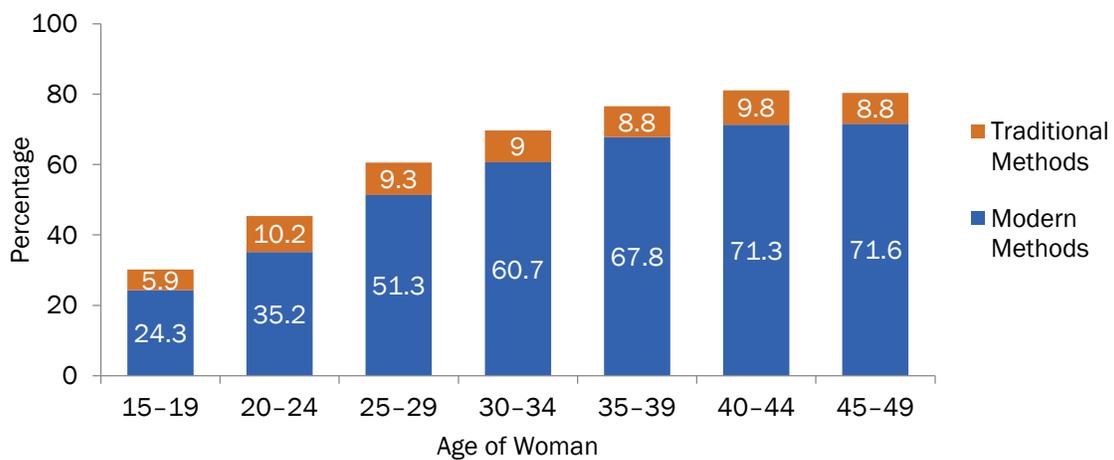


Source: Nepal DHS 2011 (MOHP et al., 2012)

Family planning demand satisfied

Young women ages 15–19 have only 25 percent of their demand for modern family planning satisfied and a slightly higher level of demand satisfied for all methods. These levels are far lower than for older women (Figure 42).

Figure 42. Demand for Family Planning Satisfied in Nepal



Source: Nepal DHS 2011 (MOHP et al., 2012)

Accessing Family Planning Services: The Current Policy Environment for Young Women Ages 15–19 in Nepal

Laws, treaties, and conventions

The 2007 Interim Constitution of Nepal emphasizes the right to reproductive health. The Interim Constitution is in force until the Constituent Assembly frames a new constitution. It declares Nepal to be a federal, democratic republican state. It emphasizes the right to reproductive health and healthcare.

The 2015 (draft) Constitution of Nepal guarantees the right to reproductive health. The draft Constitution emphasizes the right to healthcare, equal access rights of women, the right to health information, and the right to safe motherhood and reproductive health.

The 2002 National Safe Abortion Law requires parental consent for women under 16 seeking abortion. The revised legal framework allows for the termination of pregnancy up to 12 weeks of gestation for any woman, up to 18 weeks of gestation if the pregnancy results from rape or incest, and any time during pregnancy with the advice of a medical practitioner. According to the subsequent National Safe Abortion Policy resulting from this law, permission of a husband or guardian is required for women below age 16.

The Marriage Registration Act sets the legal age of marriage at 20 for men and women. According to girlsnotbrides.org, the Nepalese Country Code sets the legal age of marriage at 20 for both men and women, and sanctions violation of the law with imprisonment and a fine.

Laws set the age of consent at 16. According to ageofconsent.net, “the age of consent in Nepal is 16 years old. The age of consent is the minimum age at which an individual is considered legally old enough to consent to participation in sexual activity. Individuals aged 15 or younger in Nepal are not legally able to consent to sexual activity, and such activity may result in prosecution for statutory rape or the equivalent local law. Nepal statutory rape law is violated when an individual has consensual sexual contact with a person under age 16. This law is applicable to both heterosexual couples and homosexual men. There is no age of consent for homosexual women.”

Nepal is signatory to all relevant international treaties and conventions. These include the Universal Declaration of Human Rights, 1948; the 2000 Millennium Declaration (MDGs); FP2020 Commitments; the Sustainable Development Goals; the Convention on the Elimination of Discrimination Against Women, 1979; International Conference on Population and Development, 1994; the Convention on the Rights of the Child, 1989; the Social Development Summit, 1995; and the Beijing Platform of Action, 1995.

Policies, plans, and strategies

The 1997–2017 Second Long-Term Health Plan sets reproductive health-related goals. This 1997 Ministry of Health and Population document provides guidance and support to all sectors in formulating a rational and realistic strategy to improve the country’s health situation over the 20-year period. This plan sets goals, objectives, and targets, and lays out strategies to pursue in Nepal’s five-year development plans. It emphasizes community participation, gender sensitivity, and getting services to the most vulnerable groups (including women). The plan sets several reproductive health-related targets, and notes the need for family planning programs and **improving women’s status.** Although the suggested policies in the plan focus on increasing access to and quality of essential healthcare in general, they do not specify family planning access for young women. The plan does not differentiate by marital status. Originally written in

1997, the document continues to provide a long-term guiding framework that has laid the groundwork for later strategies and policies, such as the National Reproductive Health Strategy (1998) and the current National Health Policy (2014).

The 2014 National Health Policy mandates adolescent-friendly family planning services. It outlines 14 policies and accompanying strategies. Importantly, the policy continues to ensure universal health coverage, provides for basic health services free of cost, and specifically mandates that health organizations incorporate youth and adolescent-friendly family planning services. The policy also lays out plans to strengthen the quality of the health workforce, including increasing the skills of female community health volunteers. It encourages transparent health communication and lays out plans for a standardized school health program (though it does not mention sexual health). It mentions sexual and reproductive health and adolescent health as problem areas requiring attention. The policy states that all health organizations must incorporate youth and adolescent-friendly family planning services. There is also an overarching emphasis on health communication, school-based health programs, and improving healthcare quality and access in general. This effort includes increasing the skills of female community health volunteers, who have proven vital to family planning efforts.

The 2015–2020 Nepal Health Sector Strategy recognizes the challenges in providing services to adolescents. This strategy is the primary instrument for guiding the health sector over the five-year period ending in 2020. It adopts the vision and mission set forth by the National Health Policy and supports the constitutional provision guaranteeing access to basic health services. It articulates the **nation's commitment to achieving** universal health coverage and provides the basis for garnering required resources and investments. The document notes that over the past few decades, the government has strengthened community-based interventions and introduced programs aimed at reducing inequities in health, including the free healthcare program and safe delivery incentive scheme. As with other higher-level health strategies, it does not explicitly address family planning in a way that will have a direct impact on young women.

The 1998 National Reproductive Health Strategy prioritizes developing an adolescent reproductive health program. It defines integrated reproductive healthcare as consisting of the following:

- Family planning
- Safe motherhood
- Child health (newborn care)
- Prevention and management of complications of abortion
- Prevention and management of reproductive tract infections/sexually transmitted diseases/HIV/AIDS
- Prevention and management of sub-fertility
- Adolescent reproductive health
- Problems of elderly women—i.e., uterine, cervical, and breast cancer treatment at the tertiary level or in the private sector

In identifying adolescent reproductive health as a critical component of the integrated health package, the policy is an important milestone for access and rights in Nepal.

The 2003 National Safe Abortion Policy requires consent by a husband or guardian for women below age 16 seeking an abortion. This policy lays out a framework for rolling out safe, legal abortion services through the Comprehensive Abortion Care Program. It speaks specifically to what these services will entail, who will be able to provide comprehensive abortion care, how to disseminate

news of the new policy, how to scale up comprehensive abortion care, and how to regulate the program. The policy applies to any pregnant woman. It states that a woman below age 16 requires informed consent of her nearest relative—e.g., husband or guardian. The policy seeks to provide access to safe abortion services for all women, including young women and adolescents, both married and unmarried. The policy does not explicitly differentiate between married and unmarried women.

The National Policy on Skilled Birth Attendants does not directly address young women. The policy seeks new solutions to address the problem of lack of access to skilled birth attendants, particularly among marginalized populations. It recommends a national target of 60 percent by 2015 for the proportion of births attended by a skilled attendant. It does not define or mention youth or directly address young women. Though skilled birth attendants are presumably important conveyors of postnatal family planning information, this policy does not directly affect family planning access or rights for young women. The annex listing the core competencies of skilled birth attendants is the only mention of family planning.

The 2000 National Adolescent Health and Development Strategy emphasizes attention to both married and unmarried adolescents. This Ministry of Health document builds on momentum and recommendations from the Ninth Five Year Plan and the Second Long Term Health Plan (1997–2017), both of which recognized the need for reproductive health programs (including adolescent health). It also builds on the 1998 National Reproductive Health Strategy, which identified adolescent reproductive health as a critical component of the integrated reproductive health package. The strategy outlines the government’s aim of providing health and development services for adolescents in Nepal. Furthermore, it provides guidelines for policymakers, services providers, various line ministries, international and local nongovernmental organizations, and private sector organizations, identifying their roles and responsibilities so they can develop and implement activities within the framework of the adolescent health and development strategy. Overall, the policy emphasizes the need for multisectoral cooperation and integration. It also notes the need for gender-sensitive services, as well as attention to issues of both married/unmarried and pregnant/non-pregnant adolescents. It defines adolescents as individuals ages 10–19 years, youth as those ages 15–24 years, and young people as covering the entire age range of 10–24 years. Although the strategy covers health and development as a whole (e.g., nutrition, puberty, and education), the vast majority of the interventions and strategies revolve around sexual and reproductive health accessibility and relevance to adolescents. This strategy is critical for youth rights and access to family planning services. It operationalizes the national reproductive health **strategy’s commitment to** adolescent reproductive health, and specifically notes the challenges related to family planning services for young married women.

The 2006 National School Health and Nutrition Strategy broadly supports adolescent health but says relatively little about family planning. The main goal of this strategy is to develop the physical, mental, emotional, and educational status of schoolchildren. Four strategic objectives support this goal:

1. Improve the use of school health and nutrition services by schoolchildren
2. Improve the healthy school environment
3. Improve health and nutrition behaviors and habits
4. Improve and strengthen the community support system and policy environment

The strategy encompasses school programs jointly organized by the education and health sectors to enhance the health, nutrition, and education status of children ages 5–17 by improving the use of school-based health and nutrition services, safe water and sanitation,

skills-based health education, and community support and the policy environment. It references one family planning-related activity: mobilizing local health service providers in conducting sessions and topics during the period of teachers' training and students' orientation on such issues as helminths control, first aid, adolescent health, safe motherhood, sanitation and personal hygiene, information about existing health services and referral points, nutrition, HIV and AIDS, and STIs. The strategy does not differentiate between married and unmarried women. While it recognizes the potential for integrating health and education activities, and includes a strategy to mobilize local health service providers to conduct health education sessions on adolescent health and safe motherhood, it focuses mainly on nutrition and sanitation for young children. Thus, the impact on family planning access may be minimal.

The 2010 National Youth Policy demonstrates a government commitment to actions supporting family planning for adolescents. This policy aims to support the role of youths and their inherent capacity for building a prosperous, modern, and just Nepal while integrating them into the mainstream of national development through meaningful participation and capacity and leadership development. The policy proposes some family planning-specific activities (e.g., “youths will be trained, in coordination with health institutions, on matters such as family planning, maternal child care, right to motherhood, and child delivery gap”). The policy also identifies young women as a priority group. It does not differentiate between married and unmarried women. This policy demonstrates the **government's** commitment to some key areas that could affect family planning access for young women. Specifically, the document promotes health education, including sexual and reproductive health education, and seeks to work against harmful gender norms and practices.

Political statements

At the 2014 Girl Summit, Nepal pledged to end child marriage. The government of Nepal has pledged to do the following:

- Declare child marriage as an unacceptable social practice and a punishable crime
- Work hand in hand with adolescent girls and boys in meaningful and innovative ways to inspire and involve them in ending child marriage
- Directly engage boys and men as active participants in actions to end child marriage
- Strengthen intersectoral mechanisms within and beyond government systems to share evidence-based best practices and celebrate successful interventions to end child marriage
- Issue a call to action for all stakeholders to recognize and demonstrate their deepest commitment to this national priority of ending child marriage, and to contribute the necessary technical and financial resources toward actions for achieving this goal (UNICEF Nepal, 2016)

Operational policies, standards, and guidelines

The 2007 Implementation Guide on Adolescent Sexual and Reproductive Health for District Health Managers specifies actions to address the family planning needs of married and unmarried adolescents. This guide helps district health managers implement the Adolescent Health and Development Strategy. The guidelines encourage including adolescent and youth-friendly characteristics in all service outlets. They outline a set of principles to guide program managers in implementing the National Adolescent Health and Development Strategy 2000: accessible and acceptable health services; provision of culturally and socially accepted required services, education, and information; effective and equitable comprehensive services; and standards for adolescent-friendly services. The document defines adolescents as individuals ages 10–19 and

youth as individuals 15–24; young people covers the entire age range of 10–24. It recognizes the percentages of married adolescents and early childbearing; lack of utilization of health services among married and unmarried adolescents due to lack of money, fear of going alone, or no one to accompany them; and difficulty in getting permission to seek help, a lack of female doctors, and travel distances. In outlining implementation, the guide recommends making available a specific package of essential health services for all adolescents, both married and unmarried—including counseling and provision of reversible contraceptives, post-abortion contraceptives, and referrals for provision of reversible contraceptives not available at lower-level primary healthcare outlets. Overall, the guidelines focus heavily on improving access to youth-friendly health services, including for family planning, at all levels for married and unmarried adolescents.

The 2008 Reproductive Health Clinical Protocols include adolescent-specific clinical guidelines for both married and unmarried adolescents. These protocols aim to improve quality of care for the reproductive health of women, men, and adolescents through evidence-based protocols; standardize reproductive health at different care levels and enhance performance; standardize supplies, drugs, and equipment; improve the efficiency of the health system to increase utilization; provide the basis for skill development and developing a training manual; develop tools for monitoring and evaluation of quality of care; enable individuals and communities to receive quality care; and build health system accountability. The section on family planning provides guidance on the assessment and evaluation of client needs (family planning), identifies and provides in-depth information on spacing and limiting methods, and maps out an assessment process to guide counseling. The protocols also include sections with in-depth information on family planning, safe motherhood, newborn care, HIV, STIs, gender-based violence, abortion care, other gynecological problems, and adolescent health. The adolescent health section covers adolescent pregnancy; differentiates between married and unmarried women, with a focus on clinical guidance; and includes referrals to family planning protocols.

The 2010 National Medical Standards for Reproductive Health Services includes a section on contraception for adolescents. These 2010 standards were revised to keep up with technical advances and changes in contraceptive technology and policy. They aim to provide policymakers, district health officers, hospital directors, clinical supervisors, and service providers with accessible, clinically oriented information to guide provision of reproductive health services. The standards use the WHO definition of adolescence as ages 10–19. The section on adolescents includes topics such as counseling and referral; outlines prerequisites for adolescent-friendly services; discusses counseling and informed choice; and details various contraceptive methods. The standards highlight that marriage of adolescents is widespread; recognize pressures to begin childbearing right away; and emphasize the importance of pregnancy prevention and discussion points around the risk of STIs, unwanted pregnancy, and early childbearing with its consequent risks of complications and reduced opportunities for further education and employment. The standards highlight newly married couples and adolescents as examples for situation-specific counseling, emphasizing their need for counseling based on specific needs and situations.

Summary of the policy environment in Nepal

The assessment applied the framework discussed earlier to gauge the extent to which Nepal has a policy environment supportive of family planning access for young women ages 15–19. Nepal received an overall grade of “very supportive” based on a score of 79.7 out of a possible 100 points (Figure 43). However, it scored unevenly across the six main elements, receiving scores of highly supportive for the first three elements, but only somewhat supportive or somewhat unsupportive for the final three.

Figure 43. Grade for Policy Environment in Nepal

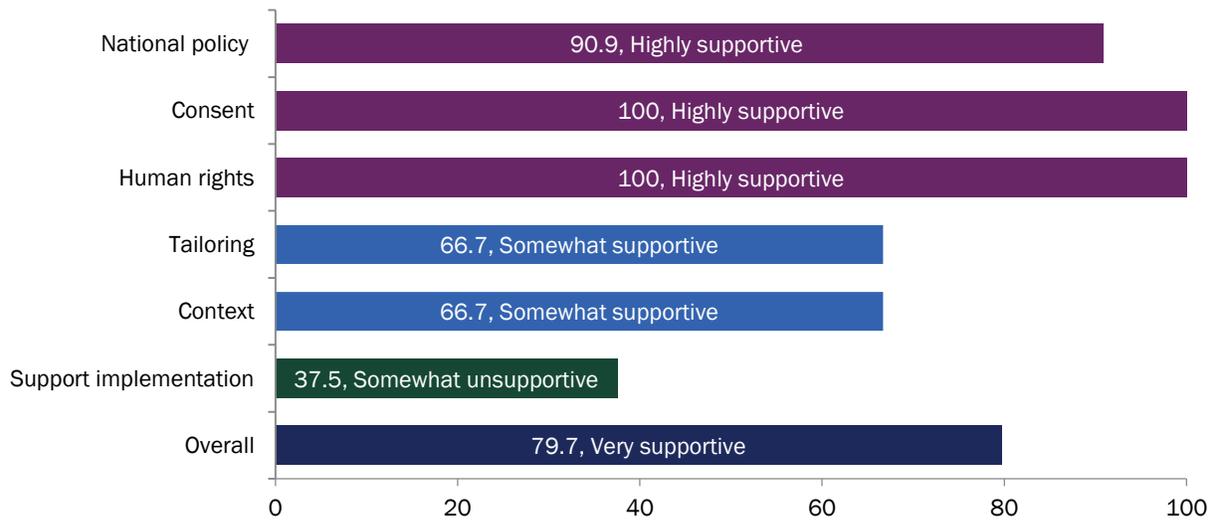


Table 3 shows the scoring breakdown by main element and individual sub-element. In the category of creating and ensuring the establishment of a national policy for adolescents, Nepal falls short only in lacking ties between national development policies and adolescent family planning. The country rates a perfect score on consent policies and promotion of human rights. When it comes to promoting a tailored approach, no policy recognizes the variation within the 15–19 age group. Within the contextual factors, Nepal lacks a policy on pregnancy and school dropout and readmission. Nepal scores worst on implementation support, lacking accountability mechanisms, lacking a specific budget line for adolescent family planning, and needing to improve its collection of adolescent-specific data.

Table 3. Assessment of Policy Environment in Nepal, by Main Element and sub-Element

Element	Yes	Partially	No	Comments
<i>Creates or ensures the establishment of a national policy on family planning for adolescents</i>				
Is there a policy that directly addresses provision of family planning to adolescents?	X			Reproductive Health Clinical Protocols 2008; Implementation Guide on Adolescent Sexual and Reproductive Health for District Health Managers; National Adolescent Health and Development Strategy; National Health Policy; National Medical Standards for Reproductive Health Services
Are there specific family planning clinical guidelines for serving adolescents?	X			National Medical Standards for Reproductive Health Services; Reproductive Health Clinical Protocols 2008; Implementation Guide on Adolescent Sexual and Reproductive Health for District Health Managers
Is there a policy that supports age-appropriate sexual and reproductive health education and information?	X			National Adolescent Health and Development Strategy

Element	Yes	Partially	No	Comments
Do policies promote the establishment of adolescent-friendly health services?	X			The National Health Policy mandates adolescent-friendly family planning services; Implementation Guide on Adolescent Sexual and Reproductive Health for District Health Managers; National Adolescent Health and Development Strategy; National Medical Standards for Reproductive Health Services
Is there a policy that provides adolescents with access to family planning post sexual assault?	X			National Medical Standards for Reproductive Health Services
Is there a policy that ensures there are no missed opportunities for appropriate integration of family planning with post-abortion care?	X			Implementation Guide on Adolescent Sexual and Reproductive Health for District Health Managers
Is there a policy that links provision of family planning to adolescents to broader family planning policies?	X			1998 National Reproductive Health Strategy
Is there a policy that links provision of family planning to adolescents to broader health policies?	X			The National Health Policy mandates adolescent-friendly family planning services; Nepal Health Sector Strategy 2015–2020
Is there a policy that links provision of family planning to adolescents to broader adolescent development policies?	X			National Adolescent Health and Development Strategy
Is there a policy that links provision of family planning to other national development plans and documents?			X	No such national development policy makes mention of adolescent health or family planning
Is the country signatory to key international agreements that support adolescent access to family planning information and services?	X			Nepal is signatory to all relevant major international agreements
<i>Ensures that consent policies and unnecessary age or marital status restrictions are not a barrier to family planning use by adolescent women</i>				
Do all policies eliminate parental consent as a prerequisite for adolescents to use family planning services?	X			National Medical Standards for Reproductive Health Services
Do all policies eliminate spousal consent as a prerequisite for adolescents to use family planning services?	X			National Medical Standards for Reproductive Health Services

Element	Yes	Partially	No	Comments
Are policies consistent with the latest WHO guidelines on medical eligibility criteria for contraceptive use as they relate to adolescents?	X			National Medical Standards for Reproductive Health Services
Do all policies eliminate consent requirements (age, parental, spousal) as a prerequisite for adolescents to use emergency contraception?	X			National Medical Standards for Reproductive Health Services
Do all policies eliminate marital status as a prerequisite for adolescents to use family planning services?	X			National Adolescent Health and Development Strategy
Do policies set an appropriate age of consent for sex?	X			
<i>Promotes human rights</i>				
Do laws and policies prohibit marriage to women younger than 18?	X			Nepalese Country Code
Do laws and policies exist that discourage the practice of female genital cutting?				Female genital cutting is not practiced in Nepal
Do policies exist that promote programs to reduce the incidence of female genital cutting?				Female genital cutting is not practiced in Nepal
Do policies exist that promote programs to reduce the incidence of gender-based violence?	X			Various laws and legal provision (University College London, 2013)
<i>Promotes a tailored approach to serving adolescents</i>				
Do policies recognize that the family planning needs of young women vary by marital status?	X			National Adolescent Health and Development Strategy; Reproductive Health Clinical Protocols 2008
Do policies recognize that, within the 15–19 age group, family planning needs vary by age?			X	No policy recognizes differences within the age group
Do policies promote a differentiated, tailored approach to providing services to adolescents?	X			National Adolescent Health and Development Strategy
<i>Addresses contextual factors</i>				
Do policies address how men and boys can support family planning use by adolescent women?	X			Government of Nepal Pledge at the Girl Summit 2014; National Medical Standards for Reproductive Health Services 2010

Element	Yes	Partially	No	Comments
Do policies view access to family planning services by adolescents as requiring a multisectoral approach?	X			National Adolescent Health and Development Strategy
Are there policies that give girls the right to education and set mandatory education levels?	X			The Constitution guarantees free education up to the secondary level; National Youth Policy
Do policies address gender-based barriers to family planning use by adolescents?	X			National Adolescent Health and Development Strategy
Do policies explicitly allow girls to remain in school should they become pregnant?			X	No policy exists
Do policies allow girls who have children to stay in school?			X	No policy exists
<i>Supports implementation</i>				
Do policies include mechanisms for accountability?			X	
Is there consistency across policies, with policies not contradicting each other?	X			
Are national statistics and data-reporting systems collecting and analyzing data disaggregated by sex, adolescent age, and marital status?		X		National surveys do not collect data on sexually active, unmarried adolescents
Does a budget line exist specifically for adolescent family planning services?			X	

Summary for Nepal

Like the other two countries discussed in this assessment, Nepal has a young population. Although the median age at first marriage has been rising, half of the women in the country are married by age 18. Nepali adolescents have the lowest rates of contraceptive use and highest rates of unmet need of any age group. Overall, the policy environment in Nepal is very supportive of adolescent family planning use, but this support is somewhat uneven across the six elements of the policy environment.

CONCLUSIONS

This comparative analysis examined the family planning needs of young women in Guatemala, Malawi, and Nepal, and how the policy environment shapes their access to services. In all three countries, adolescents ages 15–19 make up a significant proportion of the population. The economic and social environment in all three countries continues to place barriers in the way of young women seeking to achieve their sexual and reproductive health goals. Partly as a result, adolescents have the lowest use of family planning and highest unmet need for services.

All three countries have largely recognized the problems facing adolescent women and are trying to meet their family planning needs. The policy environment, as measured by the checklist used in this assessment, ranges from very supportive to highly supportive of adolescent access to family planning information and services. These countries have many of the correct policies already in place. Where gaps exist, advocates should work to add to or refine existing policies.

What matters most is how well the countries implement these policies. Although this analysis did not look in depth at implementation, there are clear signs that implementation is falling short. Further analysis is needed on how well countries are implementing key policies and what advocates can do to facilitate implementation.

REFERENCES

Bhuyan, A., A. Jorgensen, and S. Sharma. 2010. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Central Bureau of Statistics. 2014. *Nepal Multiple Indicator Cluster Survey 2014, Key Findings*. Kathmandu, Nepal: Central Bureau of Statistics and UNICEF Nepal.

Darroch, J., V. Woog, A. Bankole, and L.S. Ashford. 2016. *Adding it Up: Costs and Benefits of Meeting the Contraceptive Needs of Adolescents*. New York: Guttmacher Institute.

Health Policy Project. 2014. *Policy Checklist. Essential Elements for Successful Family Planning Policies*. Washington, DC: Futures Group, Health Policy Project.

Ministerio de Salud Pública y Asistencia Social (MSPAS). 2010. *Encuesta Nacional de Salud Materno Infantil 2008 (ENSMI 2008/09)*. MSPAS/Instituto Nacional de Estadística/Centros de Control y Prevención de Enfermedades.

MSPAS, Instituto Nacional de Estadística, and ICF International. 2015. *Encuesta Nacional de Salud Materno Infantil (ENSMI) 2014–2015: Informe de Indicadores Básicos*. Guatemala City, Guatemala.

Ministry of Health and Population (MOHP), New ERA, and ICF International Inc. 2012. *Nepal Demographic and Health Survey 2011*. Kathmandu, Nepal: Ministry of Health and Population, New ERA, and ICF International, Calverton, Maryland.

National Sexual Rights Law and Policy Database. n.d. “Malawi.” Available at: <http://sexualrightsdatabase.org/countries/363/Malawi>.

National Statistical Office (NSO). 2015. *Malawi MDG Endline Survey 2014*. Zomba, Malawi: National Statistical Office.

NSO and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

NSO and ICF International. 2016. *Malawi Demographic and Health Survey 2015–16: Key Indicators Report*. Zomba, Malawi, and Rockville, Maryland, USA: NSO and ICF International.

Ross, John, and Ellen Smith. 2010. *The Family Planning Effort Index: 1999, 2004, and 2009*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

UK Border Agency. 2008. *Country of Origin Information Report: Female Genital Mutilation (FGM)*. Available at <http://www.refworld.org/pdfid/48776e342.pdf>.

UNICEF Nepal. 2016. “Nepal Hosts Its First Girl Summit To End Child, Early And Forced Marriage.” Available at: <http://unicef.org.np/blogs/2016/03/23/nepal-hosts-its-first-girl-summit-to-end-child-early-and-forced-marriage>.

United Nations, Department of Economic and Social Affairs, Population Division. 2015. **“World Population Prospects: The 2015 Revision.” Available at:** <https://esa.un.org/unpd/wpp/>.

University College London and Centre for Research on Environment Health and Population Activities. 2013. *Tracking Cases of Gender-Based Violence in Nepal: Individual, Institutional, Legal and Policy Analyses*. London: University College London.

World Health Organization (WHO) and United Nations Population Fund (UNFPA). 2006. *Married Adolescents: No Place of Safety*. Geneva: WHO.

For more information, contact:

Health Policy Plus
Palladium
1331 Pennsylvania Ave NW, Suite 600
Washington, DC 20004
Tel: (202) 775-9680
Fax: (202) 775-9694
Email: policyinfo@thepalladiumgroup.com
www.healthpolicyplus.com

